Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 55 AM Medical Examiner Town, or Location of Death 4c. County of Death W 1 MAcma 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** X_{M2DF} -20-3096 (Month, Day, Year) ar 9,1926 Hours Director 86 Pennsylvania Mar or 28a-f show 10a. State 10b County 10c. City, Town or Location at 10d. Inside City Limits Director be notified Md. Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a 21213 Funeral 4026 Elmora Avenue Examiner must U.S.A. items ! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. .0 1 Never Married 2 Married Completed by 1 XYes 2 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. the Rail Road Administrator other 1 traumatic event, Be filed v 17. Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Sumame) Elizabeth Glogowski n and Mental F ပ Richard B. Lelonek Page 1 and 2 should be in Tent of Health and Ments 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Frances Lelonek - Wife 4026 Elmora Avenue Baltimore, Md. 21213 item 2 20a. Method of Disposition 30b. Place of Disposition (Name of S a Grife of Oceanatory or other place) 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot
once. July Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Heart of Mary Cem | 25, 2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee M00933 22. Name and Address of Facilikaczorowski Funeral Home, PA Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons CENTIFICATION APPROVED THE MEDICAL EXAMINES. or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last a consequence of burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: USe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🗆 No Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA the funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred DOA ☐ Natural 5 Pending work? Accident Suicide Investigation Director: 6 Could not be ace of njury farm, street, factory, office filled in by At hom Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Spec To the Hospital o within 24 hours aff To the Funeral Di Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Prac tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and ti icense number 29d. Date signed (Month, Day, Year) sted cause of death (Item 23a) (Type, Print) Name and address of p 0 5 GPEENE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician 1140 AM AMBERT JU*U* 2012 /Medical 4a. Facility Name (If not institution, give street and number) Apt A 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7827 East Collingham Drive Dundalk If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept9, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 244-40-6605 **Funeral** 1 ☐ M 2 🛛 F North Carolina 44 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item Z7 Is marked other than "natural" or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be nowithand as 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number Apt A 10f. Zip Code U.S.A. 21222 7827 East Collingham Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes **2**☐No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Hood Charlie Harkey ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7827 East Collingham Dr, AptA, Baltimore, Md. 19a. Informant's Name/Relationship (Type. Print) John Lambert - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July pate 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 26,2012 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. M00933 21. Signature of Funeral Service Licensee Polen 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENM **Physician** END STAGE 18 YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 NO Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation hours after death uneral Director: 6 ☐ Could not be determined 3☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2, 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAYASHI 5505 HOPKINS BAYVIEW CIRCLE BALTO, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 23503 State of Maryland / Department of Health and Mental Hygiene Andrea J. Mantheiy 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last)
 Andrea 2. Date of Death Physician/ Medical 3. Time of Death Mantheiy-Atkinson Month Year Examine 1301 hrs July 15, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign **Funeral** Country) MD Director 220-74-8720 Man Aug 10, 1970 41 1 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Cumberland 1 Yes 2 No items 23a or 28a-f show MD Allegany permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the "Ledien I vanimer must marked other han a marked other than "natural". Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15014 Laurel Ridge Rd SW 21502 Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 2 Married White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 white 3 Widowed 4 Divorced Yes, Give Yea Yes 2 No specify: Specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Dorn Frank Mantheiy nformant's Neme/Relationship (Type, Print)

Mark Atkinson ပ 19b. Mailing Address (Street and Number of Rural Roule Number. City of Town, State, Zip Code) 21502 husband 20e. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 7/20/2012 Scarpelli Funeral Home, P.A. MD Cresaptown Other e of Funeral & Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** nter the dise Between Onset and /Medical Death Immediate Cause (Final disease a Peritonitis Examiner or condition resulting in death) Due to (or as a consequence of): Perforation of Rectum Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause Metastatic Rectal Carcinoma (Disease or injury that initiated events resulting in death) Last and Physician/Medical UNPENDED the attending physician red for use as the burial **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 X Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed b ģ Eating disorder 1 Yes 2 X No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed page 1 X Yes 2 No 1 X Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26 Place of Death (Check only one) funeral director, Be Other 4 examiner' 1 Inpatient 2 X ER/Outpatient Nursing Home 5 Residence this 1 X Yes ၉ Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred on: 1 X Natural within 24 hours after death.

To the Funeral Director: completely filled in by the fi 5 Pending 1 Yes 2 No the state of Certificat Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Wedlcal** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 X 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. July 16, 2012 and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 ⁽⁴2"5 2012 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 25 per PHYS, G929, 7/25/2012, WS
State of Maryland Department of Health and Mental Hygiene For State Registrar 23504 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Marshall Physician/ Mildred | 30^{Day} June 2012 6:45 P_M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death . County of Death Baltimore 10504 Pot Spring Road Cockeysville If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 215-24-3551 Director 1 □ M 2 🕽 F 84 Oct. 30 1927 Mary land Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10h Counts 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Timonium Maryland 1 Yes 2 No 10e. Street and Numbe ō 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral U.S.A. 21093 12320 Rosslare Ridge Road "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black White etc. 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ada Sorden Geprae Brooks 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10504 Pot Spring Rd. Cockeysville, Md. 21030 Page 1 and 2 shment of Health a tant: If item 27 is Joy Anderson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or once. Druid Ridge Cemetery 7/7/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ard Medical week Examiner Sequentially list conditions, If any, leading to him surate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of, that initiated events resulting in death) Last and Due to (or as a consequence of) signed by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [≥ Division of Vital Records, aromyopath Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 욘 2 **X**No 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Spe Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 306 State Registrar

215-0036 be filed within 72 hours after death with mal Hygene. ried after than "natural", or items 23 ent, the Medical Examiner must be no	To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, Last) Gregory Paton Murphy 4a. Facility Name (if not institution, give street and number) 6101 Falls Road 5. Social Security Number 220-70-5685 Usual Residence of Decedent 10a. State 10b. County 10a. State 10b. County 10c. Street and Number 101 Charlesbrooke Road 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in Armed Forces? 1 Yes 2 Now Yes 1 Now Now Yes 2 Now Yes 1 Now Yes	yrs. last birthday) 41 Yrs. City, Town or Location altimore 10f. in U.S. 13. Was Dec if Yes, sp 1 Yes rd) 16a. Decedent's Us	y, Town, or Location of Intimore Inder 1 Year If Under 2 Inthis Days Hours Zip Code 21212 adent of Hispanic Originacify Cuban, Mexican, P 2 No specify: ual Occupation (Give kinworking life, DO NOT us	2. Date of Death Month July 23, 20 Death 2.4Hrs. 8. Date of Birth Min. 8/29/19 10 2 (Specify Yes or No- uerto Rican, etc.)	Day Year 12 4c. County of De Baltimore C. (MM/DD/YYYY) 9. If For G. Citizen of What Co U. S. A. 14. Race - Am White, etc.	ounty Birthplace (State or reign CountryMaryland 10d. Inside City Limits 1 Yes 2 No ountry?			
Funeral Director	To Be Completed by Funeral Director	Gregory Paton Murphy 4a. Facility Name (if not institution, give street and number) 6101 Falls Road 5. Social Security Number 220-70-5685 Usual Residence of Decedent 10a. State 10b. County Maryland 10b. County Maryland 10c. Street and Number 101 Charlesbrooke Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 4 17. Father's Name (First, Middle, Last) John Murphy	yrs. last birthday) 41 Yrs. City, Town or Location altimore 10f. in U.S. 13. Was Deciff Yes, sp 1 Yes during most of	Inder 1 Year If Under 2 Inder 2 If Under 2 Inder 3 If Under 2 Inder 4 If Under 2 Inder 5 If Under 2 In	Month July 23, 20 Death 24Hrs. 8. Date of Birth Min. 8/29/19 10 ? (Specify Yes or No- uerto Rican, etc.)	Day Year 12 4c. County of De Baltimore Co 1(MM/DD/YYYY) 9.1 9.70 g. Citizen of What Co U. S. A. 14. Race - Am White, etc. Specify: Wh	0235 hrs eath ounty Birthplace (State or reign CountryMaryland 10d. Inside City Limits 1 Yes 2 No ountry?			
Director	To Be Completed by Funeral Director	4a. Facility Name (if not institution, give street and number) 6101 Falls Road 5. Social Security Number 220-70-5685 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 101 Charlesbrooke Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 4 17. Father's Name (First, Middle, Last) John Murphy	yrs. last birthday) 41 Yrs. City, Town or Location altimore 10f. in U.S. 13. Was Deciff Yes, sp 1 Yes during most of	Inder 1 Year If Under 2 Inder 2 If Under 2 Inder 3 If Under 2 Inder 4 If Under 2 Inder 5 If Under 2 In	24Hrs. 8. Date of Birth Min. 8/29/19 7 (Specify Yes or No- uerto Rican, etc.)	4c. County of De Baltimore C. D. (MM/DD/YYYY) 9. I. Portion of What C. U. S. A. 14. Race - Am White, etc. Specify: Wh	ounty Birthplace (State or reign CountryMaryland 10d. Inside City Limits 1 Yes 2 No ountry?			
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any	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Baltimore 10c. of Baltimore 101 Charlesbrooke Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced or Decedent Serving Armed Forces? 1 Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 4 17. Father's Name (First, Middle, Last) John Murphy	City, Town or Location altimore 10f. in U.S. 13. Was Dec If Yes, sp 1 Yes during most of	Zip Code 21212 adent of Hispanic Originacify Cuban, Mexican, P 2 No specify: ual Occupation (Give kinworking life, DO NOT us	8/29/19 10 ? (Specify Yes or No- uerto Rican, etc.)	g. Citizen of What Co U.S.A. 14. Race - Am White, etc. Specify: Wh	10d. Inside City Limits 1 Yes 2 No ountry?			
nore, MD 21215-0036 *ages 1 and 2 should be filed within 72 hours after death with the Maryland nti of Health and Mental Hyggene. It: If item 27 is marked atther than "natural", or items 23a nr 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Baltimore 10c. 6	in U.S. 13. Was Dec If Yes, sp 1 Yes during most of	edent of Hispanic Origin ecify Cuban, Mexican, P No specify: ual Occupation (Give kin working life. DO NOT us	? (Specify Yes or No- uerto Rican, etc.)	U.S.A. 14. Race - Am White, etc. Specify: Wh	1 Yes 2 No			
nore, MD 21215-0036 *ages 1 and 2 should be filed within 72 hours after death with the Maryl ric of Health and Mental Pygene. It: If item 27 is marked atther than "natural", or items 23a nr 28a- other traumatic event, the Medical Examiner must be notified at.	To Be Completed by Funeral	101 Charlesbrooke Road 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 N 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 4 17. Father's Name (First, Middle, Last) John Murphy	in U.S. 13. Was Dec If Yes, sp 1 Yes 16a. Decedent's Us during most of	edent of Hispanic Origin ecify Cuban, Mexican, P No specify: ual Occupation (Give kin working life. DO NOT us	? (Specify Yes or No- uerto Rican, etc.)	U.S.A. 14. Race - Am White, etc. Specify: Wh	nerican Indian, Black,			
nore, MD 21215-0036 **ges 1 and 2 should be filed within 72 hours after death with an of Health and Mental Hygiene. **Hi If item 27 is marked inter than "natural", or items 2, other transactic event, the Medical Examiner must be a Transactical Learning and the manual personal states of the Medical Examiner must be a Transactical Learning and the manual personal states of the Medical Examiner must be a manual personal states of the Medical Examiner must be a manual personal states of the Medical Examiner must be a manual states of the Medical Examiner must be a manual states of the Medical Examiner must be a manual states of the Medical Examiner and the manual states of the Medical Examiner and the manual states of the Medical Examiner and the Medical Examiner	To Be Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed College (1-4 or 5+) 4. Armed Forces? 1 Yes 2 Nor Dates: 15. Decedent's Education (Specify only highest grade completed College (1-4 or 5+) 4. Tr. Father's Name (First, Middle, Last) John Murphy	No 1 Yes, sp 1 Yes ad) 16a. Decedent's Us during most of	ecify Cuban, Mexican, P 2 No specify: ual Occupation (Give kin working life. DO NOT us	uerto Rican, etc.) d of work done	White, etc. Specify: Wh				
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nore, MD 21215-0036 *ges and 2 should be filed within 72 *in of Health and Mental Hygiene. *it: If item 27 is marked nither than ", other traumatic event, the Medical F	To Be	17. Father's Name (First, Middle, Last) John Murphy	_	-	o rearea)		ss/Industry			
nore, MD 21215-01 *ges 1 and 2 should be filed with the filed with the filed by the filed price of the file	To Be	John Murphy		, lanagemento.	5	Verizon				
nore, MD 2121 ages 1 and 2 should be t ent of Health and Mental nt: If item 27 is marke, other traumatic event] ۴	John Murphy		18.Mother's I	Name (First, Middle, M	aiden Surname)				
nore, MD ages I and 2 sho ont of Health and at: If item 27 is other fraumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr	Barbar Street and Number		per. City or Town Sta	ate. Zin Code)			
ages l and of the land of the		Kelly Ann Murphy / Wife		lesbrooke F						
E 8 # # 6		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	20b. Place of Disposition (crematory or other pla		Date	20c. Location - City	or Town, State			
		4 Donation 5 Other Specify:	Hilltop Serv	. Corp.	7/28/2012	Towson,	Maryland			
Ba Dermi Depar Impo		21. Signature of Funeral Sandice Licensee	22. Name a	nd Address of Facility York Road	Ruck Towson	Funeral	Home, Inc.			
J Han See L	miner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last Intraoral Shotgun Wound Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): d.								
8 8 8 .S	<u>ē</u> -	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal dea		egnancy	23d. Date of delive Month	ery Day Year			
P.O. Bo es that the de igned by the se detached fi	by Phy	Part II. Other significant conditions contributing to death but n	not resulting in the underly	ing cause given in Part I			to the cause of death?			
Division of Vital Records, P.O. tal ar Attending Physician: The law requires that the saferd ceath. After this certificate has been signed by led in by the funeral director, page 2 should be detach artification. To Be Commissed by Darification.	Completed				24a. Was ar autops:	24b. Were	autopsy findings available completion of cause of			
ital Rec iician: The l s certificate h irector, page		25. Was case referred to medical		26.Place of Death (Ch	1 Yes 2	No1 ✓ `	Yes 2 No			
Vita hysicis this ce all direct	o Re	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3	100-	ursing Home 5 R	esidence 6 🗸 Oth	ner: Scene			
DIVISION OF To the Hospital ar Attending Pl within 24 hours after death. To the Fuoeral Director: After completely filled in by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Jul 23, 2012	28b. Time of Injury FOUND: 0215 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	Subject shot	w injury occurred self				
DIVIS Dital nr At urs after d ral Direc illed in by	5	3 Suicide 6 Could not be determined (Specify) Under B	At home, farm, street, fact	ory, office building, etc.	28f. Location (Str or Town, Sta 6101 Falls Roa	te)	Rural Route Number, City			
To be set of the control of the cont										
H × F 8		and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (M. 3 July 23, 2012								
19x.		 Name and address of person who completed cause of death (I Melissa Brassell, MD Assistant Medical Exar 	miner 900 W Bal	timore Street, Balt	imore, MD 21223					
Stat Registra	_	31. Date filed (Month, Day, Year) 25 2012 Registrar's Sign	nathe parket							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 29M Month Year **Physician** Ju 2012 ane /Medical County of Death 4c 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M Mar. 25, 1939 MD Director 217-38-0765 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a, State 10b. County 1 Yes 2 No Director MD Baltimore City 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 6 4905 21206 ral", or ttems 23a o Examiner must be Sinclair Lane USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black ş 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) remit. Pages 1 and 2 should be filed within 7 Leg artment of Health and Mental Hygiene. I protant: If item 27 is marked other than "ne my injury or other traumatic event, the Medic one. Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Cook 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George A. Robinson Florence L. Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1700 McCulloh St. Balts, Md. 21217 19a. Informant's Name/Relationship (Type. Print) Shirley Robinson (sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carmel Cem. July 27,2012 Balto,Md. 22 Name and Address of Facility Calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Licensee 21213 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SC Physician VI Pass /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 1 Live birth 3 - Ectopic pregnancy Month Vear Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) detached f P.O. 9 Unknown 9- Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 pe 2 No 3 Probably 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 🗆 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home Hospital: 1 \square Inpatient 2 DE Outpatient з 🗌 DOA 5 Residence 6 Other (Specify) ဂ within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Natural 1 Yes 2 No М 2 🗀 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide the Hospital Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00028684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

11595

31. Date filed (Month, Day, Year)

ORIGINAL

faces

4940 Eastern Avenue, Baltimore, MD, 21224

5. Bessmon

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,	
the Hospital or Attending Physician: The law requires that the death certificate be executed	Phy /M Exa
At House arter dearth.	e
the Funeral Director: After this certificate has been signed by the attending physician and	ic di ni
and to be the final director page 2 should be detached for use as the burial-transit	ic

		Please Type or Print in Bl State of Maryland					_	
		For State Registrar		tificate of D		Reg	0.01	2 23507
Physicia /Medic	in al	1. Decedent's Name (First, Middle, Last) Leo 5 MCKenna				2. Date of Death Month July 2	Day 2012	1525 PM
Examine	er	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center		4b. City, Town, or I	Location of Death	,	4c. County of Dea	
Funeral Director		5. Social Security Number 213-05-7624 6. Sex 1 [XM 2 F] 7. Age (In yrs. last 2 95]	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 04/02/1	ar) 9. Bii	rthplace (State or Foreign buntry) RYLAND
vland low It		Usual Residence of Decedent 10c. City, 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
he Mary 28a-f sh otified a	Director	MD N/A	BAL	TIMORE		10-	. Citizen of What Co	1 X Yes 2 □ No
h with t	al Dir	10e. Street and Number 3609 FAIT AVENUE		10f. Zip-Code	224	Tog	U.S.	
items items	Ē	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No	13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	3X Widowed 4 □ Divorced If Yes, Give Year or Dates 1942-4	5	1 □ Yes 2 No	Specify:			VHITE
nin 72 h n "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of work		6b. Kind of Busines:	s/Industry
led with ygiene her tha t, the N	Com	17. Father's Name (First, Middle, Last)	-	LITHOGRA		e (First, Middle, Ma	PRINT	ING
ld be fi ental H ked otl ic even	To Be	BERNARD MCKENNA			MARY	, ,	DOR	SEY
2 shou and M is mar raumat		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a				. ,
s 1 and f Health item 27 other tr	-	20a. Method of Disposition 20b. Pla	ce of Dispo	OVEFIELD position (Name of matory or other place			LL, MARY c. Location - City o	LAND 21128 r Town, State
. Pages 1 ment of H tant: If iter jury or oth		4 Donation 5 Other (Specify)		HEART O	F JESUS			
permit. Departr Importa any inju		21. Signature of Funeral Septice Licensee		LTLLY & C	ZETĽER CONKLING	INC FU STŘEET	NERAL H	OME 21224 ORE,MD
		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
Physician ⊱/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conseque Sequentially list conditions,	Sp;	ration o	f gastri	C Conte	ndt	5m. Nutes
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	edi	d						
The law requires that the death certificate the bas been signed by the attending physipage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 [Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year
uires that the signed by ald be detailed	ρ	Part II. Other significant conditions contributing to death but not resul	ting in the	underlying cause giv	ven in Part I.	23e. Did toba		to the cause of death? Probably 42 Unknown
e lay has ge 2	Completed		·			24a. Was an autopsy performe	prior t	
	Be	25. Was case referred to medical examiner? 1 M Voc. 2 T No.	B/O. 1	Othe	2r°	h (Check only one)	- 0 Other (0-	/4.)
Phys this ral d	인 : L	27. Manner of Death 28a. Date of Injury 2	R/Outpatier 28b. Time o Injury	11 3 LI DOA	y at	28d. Describe how	ce 6 Other (Sp	ecity)
Attending Physician: or death. sctor: After this certific by the funeral director.	ertification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At hom		M 1 []	Yes 2 No	28f. Location (Stre	eet and Number or	Rural Route Number,
s after al Direct	Certif	4 ☐ Homicide determined building, etc. (Specify)				City or Town,		,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier (cheak only one) 1 **Certifying Physician: To the best of my knowl 2 **Dedical Examiner: On the basis of examination and manner stated.						
To the within com	Σ	29b. Signature and title of certifier		29c. License	S972	39	d. Date signed (Moi	nth, Day, Year)
1. V		30 Name and address of person who completed cause of death (kern	23a) (Type	, Crint)	4940 E	astern Ave	nue, Baltim	nore, MD, 21224
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu 32. August A.	face	W				

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	Maryland		rtment of			lental Hy	giene	- 4 0	00500	
			State Registrar			Cer	tificate o	f Death	7		Reg. No. 2	112	23508	
	Physicia	_	Decedent's Name (First, Middle, L		1					2. Date of De	ath	Year	3. Time of Death	
	Medic	al	Kayode	Oyet			4b. City, Town	or Locatio	on of Death	2414			103 1	
	Examin	er	4a. Facility Name (if not institution, g Villa Rosa Nursi		er)		Mitche				4c. County of Death Montgomery			
	Funeral				Age (In yrs. la	st birthday)	If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign	
	Director		None	1 🔀 M 2 🗆 F	61	Yrs.	Months Day	ys Hours	Min.	(Month, Da July 2	y, Year) 1, 1950	Count Mamf	e, Cameroon	
	- MC		Usual Residence of Decedent			, Town or Loc	ation .					11	Od. Inside City Limits	
	yland -f sho ed at	턍	10a. State 10b. County DC		1	ingtor						- 1"	1 ፟X Yes 2 ☐ No	
	e Mau r 28a notifi	Director	10e. Street and Number		Wasii		10f. Zip Cod	e			10g. Citizen of	What Coun		
	ith th		1000 New Jersey	Avenue #	420			0003			Nige		e	
	ems arm	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S	. 13. V	Vas Decedent of Yes, specify C		Origin? (Spe	cify Yes or No-		14. Race - American Indian,		
9	or it	by F	1 Never Married 2 🔀 Marrie				Yes, specify C			Hican, etc.)		ck, White, e		
ဗ္ဗ	urs af ural", al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Date	es.				ny.			Black		
5-("nat	lg	15. Decedent' (Specify only highest	s Education grade completed)		(Give I	lent's Usual Oc kind of work do D NOT use retir	ne during m	ost of worki	ing	16b. Kind of E	Business/Inc	lustry	
12	ithin 7 ene. • than he M	Completed	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)		gineer	ea)			Gove	rnment		
d 2	Hygin Other ent, t	Be	17. Father's Name (First, Middle, Las					18. Mc	other's Nam	e (First, Middle	Maiden Surnan	ne)		
lan	be fil lental rked tic ev	은	David Oluku:	nle	Oyefolu	1		Ch	ristia	ana .	Abeke	Nee	Akinbode	
ary	hould and N is ma	- 1	19a. Informant's Name/Relationship	(Type, Print)							er, City or Town,			
Σ	ealth n 27 ner tra		Olufunke Oyefol	u / Wife									OC 20003	
ore	e 1 ar i of H if itel		20a. Method of Disposition 1	B Removal from S	+a+a C0	emetery, cren	sition (Name of natory or other	place)	i	Date 4. / 2.0.1.2	20c. Location	-		
Ë	t. Pag tment tant: jury o	_	4 Donation 5 Other (Sp.	ecify)	IKO	yi Čem					Ikoyi,			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amp injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign sure of Fundal Service 46	ensee									ne, Inc. Land 20785	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List on	omplications that ca	used the death								Approximate Interval Between	
in	Physician/		Immediate Cause (Final disease or condition	Me.		ric	Panci	two	ic (Lance	~		Onset and Death	
	Medical Examiner		resulting in death)	a.	r as a consequ		<u> </u>							
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0	nat the death certificate be executed ed by the attending physician and detached for use as the burial-transit			d										
Box 68760	The law requires that the death certificate rate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medical												
89	ending use	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna irth 2 🗆 Feta		Ectopic pregr	nancy			1	ate of deliv		
Bô	death he atte	sici	in the past 12 months? 1 Yes 2 No		ant at time of o		Other (specify	y)			l N	lonth	Day Year	
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о. С.	v requires that s been signed t should be det	Completed by	Deep Venou		1200/		, 0	5		1 🗆	Yes 2 No	3 🗌 Pro	bably 4 Onknown	
rds	requir	etec	201000000	Embolis	1000					24a, Wa	an 24b	. Were auto	psy findings available	
တ္ထ	has the	lg l	20/monary		arct					auto	opsy ormed?	death?	mpletion of cause of	
Ä	ician: The la certificate ha rector, page	Hence (are brain Interest to medical 1 yes 2 1 No 1 yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one)										2 L No		
/ita	Physician: this certific ral director,	To Be	examiner? 1 \sum Yes 2 \sum No	Hospital:	npatient 2 🗆	ER/Outpatie		0.11	,		idence 6 🗆 Ot	her (Specify)	
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	ttending death. ctor: After y the fune	fica	1 Natural 5 Pending 2 Accident Investiga	ation	.,,,			1 🗆 Yes 2	2 🗆 No					
Division	after de Directo	Certificate:	3 Suicide 6 Could n 4 Homicide determin	reet, factory, off	ice			(Street and Num wn, State)	ber or Rura	Route Number,				
29a. Certifier 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and										and place, and c	lue to the ca	use(s) and manner stated.		
	To the within 2 To the comple	2	29b. Signature and title of certifier					ense numb		25	29d. Date sign			
			Voul	38c	S	03c) /T:=-	Print\	NOO	3 3 3.	J J	0414	10 2	010	
-	5V		30. Name and address of person w	COUMD		23a) (Type,	ottsfe	Thre	Dive	Mit	thellu,	lle, M	1d	
	Sta Registi		31. Date filed (Month, Day, Year)	112 Pend	egistrar's Signa	ture far	la l							

DHMH 17 Rev 06-2011

12-05409 Je

effrey Polczyns			d / Department	of Health and Mental I		012 23509						
		1- For State Registrar	Certificate	of Death	Reg. No.	3. Time of Death						
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last) Jeffrey Polczynski			Month Day Year July 18, 2012	2130 hrs						
1		4a. Facility Name (if not institution, give street and number 8542 Foxborough Drive, Apt 1C	er)	4b. City, Town, or Location of Dea Savage	th 4c. County of Howard	Death						
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)									
Director		207-56-3703 1∑M 2□F	51 Y	Yrs. Months Days Hours M	" June 10,1961	Foreign Country)Pennsylvania						
ķ		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Loc	cation		10d. Inside City Limits						
- A - 3		Maryland Howard	Savage	34101		1 Yes 2 No						
ne Maryland nr 28a-f shnw any fied at once.	향	10e. Street and Number		10f. Zip Code	10g. Citizen of Wha	at Country?						
he Ma in 28	Director	8542 Foxborough Drive,	Apt.1C	20763	U.S.A.							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department. Of the and Mental Hygievic. Department of the and Mental Hygievic. Inapprint of item 27 is marked niter than "natural", or items 23a nr 28a-f shin injury or other traumatic event, the Medical Examiner must be motified at once.				Was Decedent of Hispanic Origin?		- American Indian, Black,						
death or iter	Funeral	1 Never Married 2 Married Armed Ford 1 Yes, Give Year 3 Widowed 4 Divorced It Yes, Give Year	2 N82	If Yes, specify Cuban, Mexican, Puer		White						
s after ral",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade		Yes 2 No specify:	Specify: f work done 16b. Kind of Bus							
2 hour	ted	Elementary/Secondary (0-12) College (1-4	or 5+) during	most of working life. DO NOT use re	otired) United							
D36 thin 7 ne.	Completed	12	Diplo	omatic Security (Officer Departme	ent of State						
5-0 led wi Hygie nather		17. Father's Name (First, Middle, Last)			ne (First, Middle, Maiden Surname)	1-:						
21215-0036 uld be filed within 7 Mental Hygienc. marked other than	Be	John William Polczynski 19a. Informant's Name/Relationship (Type, Print)	10h Mai	ling Address (Street and Number o	nce Louise Olszev							
MD 2 d 2 shoul lith and M in 27 is m	1º	John W. Polczynski		Hastings Avenue								
and 2 and 2 Health item 2		20a. Method of Disposition	20b. Place of Disc	position (Name of cemetery.	Obste 1 0 20c. Location -	City or Town, State						
Baltimore, permit. Pages l ar Department of Hee Impartant: If ite		1 Burial 2 X Cremation 3 Removal from	Pittsbur	gh Cremation Ser	vice Pittsbu	rgh,Pennsylvania						
altir mit. F partme parts		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		2. Name and Address of Facility								
E L Ce M		michael P. margullo	6	009 Harford Road	,Baltimore,Maryl	and 21214						
Physician /Medical		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.				rt Approximate Interval Between Onset and Death						
Examiner				sclerotic Cardio	vascular Disease	Deau						
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.										
	iner	if any, leading to immediate Due to (or as a co	onsequence of):									
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Box 68760, edeath certificate be the attending physici de for use as the burit	sicia	4□ Vo. A□ Vo. A□ University □□		Other (Specify)								
he d	Physician/Med	Part II. Other significant conditions contributing to c		ne underlying cause given in Part I.	23e. Did tobacco use contrit	bute to the cause of death?						
P.O es that t igned by	by				1 Yes 2 No 3	Probably 4 🗹 Unknown						
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To the Hos within 24 h To the Fun	(Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated when the cause of t											
L>F5	ž	29b. Signature and title of certifier		29c. License number		ed (Month, Day, Year)						
		Met 2		O.C.M.E.	July 19, 20	12						
e pom		30. Name and address of person who completed cause Ana Rubio M.D., Ph. D. Assistant M		00 W. Baltimore Street, Bal	timore, MD 21223							
S	tate	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature									
Regis	trar	JUL 2 5 2012 Beneva &	. parks									

H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Faye (E. Parks-\		O S 1- For State Registrar	tate of Maryla		artment of		nd Mental H		Reg. No. 2	012 2351
Medic	Physic cal Exam	ian/	Decedent's Name (First, Midd Faye E. Parks				_		2. Date of De Month July 19, 2	ath Yea	3. Time of Death
			4a. Facility Name (if not institution 3100 Hamilton Avenu	on, give street and nu	mber)	41	o. City, Town, or Baltimore	r Location of Dea		4c. County o	
	Funeral Director		5. Social Security Number 218-68-6364	6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	Months Days Hours Min			9/1957	9. Birthplace (State or Foreign Country)Maryland
	ryland a-f show any f once.	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number			Town or Location	n 10f. Zip Code			10g. Citizen of Wh	10d. Inside City Limits 1 XYes 2 No
	n with the Maryland ms 23a or 28a-f show be notified at once.	uneral Director	3100 Hamilton 11. Marital Status	lton Avenue Apt. 12. Was Decedent Armed Forces?			21214 Decedent of Hi	spanic Origin?(Specify Yes or N	U.S.A.	- American Indian, Black,
	us after death tural", or iter tminer must	by Fun	1 Never Married 2 N 3 Widowed 4 Div 15. Decedent's Education (Spe	1 Yes	2 X No	1 1	Yes 2∭ No	n, Mexican, Puerl specify: tion (Give kind of		Specify:	White
5-0036	permit peges I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked attler than "natural", or items 23s or 23s-f she injury ar attler traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1			st of working life	e. DO NOT use re	tired)	Own he	•
2121	ould be filed Mental Hyg marked ntl	Be	17. Father's Name (First, Middle Charles W. Pa 19a. Informant's Name/Relations	arks ship (Type, Print)	<u> </u>	19b. Mailing	Address (Stree	Evelyn	Lowery Rural Route Nu	Maiden Surname)	n, State, Zip Code)
MD	es 1 and 2 sho of Health and If item 27 is		Evelyn Sweetin 20a. Method of Disposition 1 Burial 2 X Cremation		om State	Hamilton ion (Name of ce place)	n Avenue	Baltim 7/23/12	ore, Mary	/land 21214 City or Town, State	
Baltimore	permit. Page Department Important: injury or nt		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	Cre	mationCe 22. Na 600	me and Addres	s of Facility	rzullo	Tuneral	maryland hapel, F.A. yland 21214
	hysician /Medical xaminer	N 3	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	e Intox	Do not enter the				,	
	kecuted and ransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b									
ģ	be est	edical	X UNPENDED			1,27,28	a-f,per	me,g929	7-30-1		
Box 6876	To the Hospital or Attendiog Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the br	hysician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	ne 1 Live bi 4 Pregna known 9 Unkno	ant at time of dea	2 Feta	I death 3 er (Specify)	Ectopic pregr	ancy	23d. Date of o	delivery Day Year
S. P.O.	uires that the de in signed by the Id be detached f	ব	Part II. Other significant condit	ions contributing to	death but not re	esulting in the un	derlying cause (given in Part I.	1Ye	es 2 No 3	oute to the cause of death? Probably 4 Unknown
) Division of Vital Records. P.O.	ysician: The law requir his certificate has been s director, page 2 should	Completed	25. Was case referred to medica	4			26 Diago	e of Death (Check	1 Yes	psy pr prmed? de	/ere autopsy findings available for to completion of cause of eath? Yes 2 No
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sion o	or Attendiog Phatter death. Director: After I in by the funeral	Certification:		stigation fd 7-	Day, Year) -19-12	28b. Time of Injune of Inj	O par 1	ry at Work? Yes 2 X No	unknow		
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4)	To the Hospital within 24 hours To the Funeral completely filled	Medical		miner;On the basis o and manner st	f examination ar			, death occurred		and place, and du	e to the cause(s)
		-	Name and address of person		e of death (Item	23a)	O.C.			July 20, 201	d (Month, Day, Year)
	6	210	Russell Alexander ME 31. Date filed (Month, Day, Year)). Assistant M		iner 900 V		Street, Baltir	more, MD 21	223	
	اد Reais		111 2 5 2			par					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 23511

		1- For State Registrar Registrar 1.10 Decedent's Name (First, Middle,Last) 2. Date of Death 2. Date of Death 3. Time of Death 3. Time of Death 4. The Death Back of Death Back of Death 4. The Death Back of D																	
Physi	cia			e (First, Midd	le,Last)								2	Date of De	ath			3. Time of D	eath
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			4a. Facility Name (if not institution	n, give str	eet and nu				b. City, 7	Fown, or Lo	ocation of		,,		c. County of	Death		
			5408 Jeffer	son Pike						Frede						Frederick			
Funera	. I		5. Social Security N	Number	6. Sex		7 Age (Ir	n yrs. last	hirthday)	I If I Inde	er 1 Year	If Under:	24Hrs	8 Date of F	irth (NANA	/DD/WWWI	9 Rin	hplace (State	or
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Mer Mer	<u>ا</u> ق	2	19a. Informant's Na	me/Relations	hip (Type,	Print)		1	19b. Mailing	Address	(Street a						State,	Zip Code)	
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Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. 1 fire 27 is marked other than "natural", or items 23s or 28s-f should the manual	or other traumane event, the Medical Examiner	ı	20a. Method of Dis	position					e of Disposi			etery,		ate	20c.	Location - C	City or	Town, State	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: Hitem 27 is marked other than "matural", injuryed other transmissions.			21. Signature of Fu	neral Service	Licensee		^		22. N	ame and	Address o							al Serv	
E C E			All	en	S	2 MS	77	20										cia, V	A 2231
Physicia			23a. Part I. Enter th	ne disease, or	complicati	ons that ca	used the	death. Do	not enter th	e mode d	of dying, su	uch as card	diac or re	spiratory a	rest, she	ock, or hear	t	Approximat	
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the dead	8 .	إخ			9														
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i, P.O. Box 68' ires that the death certification is given by the attending labeled for use as	2 :	g S												1 Ye	s 2 🔻	No 3	Prob	ably 4 U	nknown
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diog Ph	ן וַנַּי	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred																	
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attendiog Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functural Director: After this certificate has been signed by the attending physician and completely filled in which finested increase 2 should be deathed for use as the busis! Harse																			
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To t	1103	Medical	2		and	manner st		ori uriu/U					udil	o uno, uale					
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-1			1 Q Ca	tulo	ell)					O.C.M.	E.			July	22, 201	2		+
(1)		ŀ	30. Name and addr	ess of person	who comp	leted cause	e of death	(Item 23a	a)					-					
Y			Laron Locke						00 W. Ba	ltimore	Street.	Baltimo	re, MD	21223					
	Sta	te	31. Date filed (Mont				gistrar's S												-
Regi		_	_	2012	Á			her	1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Pate of Death Physician/ PLOUDEN ONAL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Baltimore Randlestown Season Hospice NW Hosp If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (19 yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 212-32-6518 3 /19 /35 Year) (Country) Director 1 ÅM 2 □ F 1 end 2 should be filed within 72 hours efter deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "nature!", or Items 23a or 28a-f show other treumatic event, It is Medical Exchanged by notified at 10c. City, Town or Location Baltimore 10b County 10a. State 10d. Inside City Limits Directo N/A MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 4407 Belvieu Ave 21215 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No African Specify: Amer. Be Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Glass Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 7. Father's Name (First, Middle, Last) Theodore Plowden 18. Mother's Name (First, Middle, Maiden Sumame)
Dorothy Plowden ည 19a Informant's Name/Relationship *Type, Print)* Clara Plowden/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4407 Belvieu Ave, Balt., MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt., MD 7/28 Date/12 permit. Pege 1 of Pepartment of Pepartment of Pepartment: If its any Injury or of once. cemetery, crematory or other place)

It. Zion Cem. 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fluneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate rame. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): siclan and burlal-trensit Exami that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiclan I for use es the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day signed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The lew requires t within 24 hours after death.
To the Funnerel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be cete has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death red at the time, date and place, and due to 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 50 pm Physician/ JOHN T. ROHE 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square Baltimore FRANKLIN HOSPITal Rosedale 6. Sex Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Country) Director 218-14-6320 90 XX M 2 - F June 1,1922 MD. Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director Maryland Baltimore Baltimore County 1 Yes XX No 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21236 USA 4222 Fitch Avenue Examiner must items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married X Yes 2 No 11 Yes, Give WW 11 Maryland 21215-0036 1 Wes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) John Builder Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Rohe Mary Christ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert T. Rohe (Son) 21712 Orwig Rd. Freeland, Md. 21053 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-28-2012 Gardens of Faith Baltimore. Md Any ure of Funeral Service Cidensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra Phytician/ abdominal disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) bowel obstruction The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical incarcera hernia Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Day Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 100 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \[Yes 2 \[No 1 Natural injury 5 Pending I Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21/23/12 D64480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

DR MustaFa

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Hassanali Fidahussein 9000 Franklin Square DR Balto Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month CHRISTINE ELISE RENAUD :09P M 2012 Medical TIIT.V 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHARLES WALDORF 20 MOONCOIN CIRCLE Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. JANnth, Pay, Year) 9 7 5 Director 220-80-9055 37 1 M 2 X F WASH., DC show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sh notified WALDORF MD CHARLES 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. 10e. Street and Number ö must be 20602 23a Funeral 20MOONCOIN CIRCLE items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces ↑

1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married 0 þ 1 ☐ Yes 2 🗙 No Specify Baltimore, Maryland 21215-0036 Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) the AT HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ VICKI LYNN RENAUD ROBERT JOSEPH MOCCIA 19a. Informant's Name/Relationship (Type, Print) g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORTHGATE PLACE WALDORF, MD 20602 BOBBY JO RENAUD-TASH 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o ō cemetery, crematory or other place METRO.CREMATORY 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 07/17/2012ALEXANDRIA, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYHOND FUNL.SERVICE, F.A. Signature of Funeral Service Licenses 5635 WASHINGTON AVE., LA PLATA, MD 20646 Set M00641 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or iac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Frysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 G the detached g | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has death? Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 5 Pending injury 1 Yes 2 No 2 Ccident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

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the

within To the

only one)

29b. Signature and title of certifi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 Dood

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	aryland / Dep <i>Cei</i>	artment of F rtificate of E			ene g. No. 2 N I	2 23515
Physic	ian/	1. Decedent's Name (First, Middle,		n-11-			2. Date of Death July 21		3. Time of Death 7:35 p M
Med Exam	ical	James 4a. Facility Name (if not institution, g	Vincent give street and number)	Rallo	4b. City, Town, or	Location of Death	<u> </u>	4c. County of De	
- LAGIII	ii Ci	Oak Crest				ville		Balti	
Funera Directo	_	5. Social Security Number 213–10–2335 Usual Residence of Decedent	5. Sex 7. Age	(In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You Nov 15,	1915 Ne	Birthplace (State or Foreign Country) PW York
aryland a-f show ified at	ector	10a. State 10b. County	ltimore	10c. City, Town or Lo	ville				10d. Inside City Limits 1 Yes 2 X No
with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 8830 Walther	Blvd.		10f. Zip Code	1234	10	g. Citizen of What (
laryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ender Armed Forces? 1 Yes 2 In If Yes, Give Year or Dates.	No.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Vhite
21215-0036 within 72 hours after giene. her than "natural", o	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4 or 5-	(Give	dent's Usual Occup kind of work done o DO NOT use retired) Sales	ation luring most of work	rim or	6b. Kind of Busines Greeting rapping	
Maryland 2 2 should be filed w Ith and Mental Hygi 27 is marked other traumatic event, i	To Be	17. Father's Name (First, Middle, La Gioachino	st)	Rallo		18. Mother's Nan Maria	ne (First, Middle, Ma a	iden Surname) Gueri	:a
lary should and M is mai	Т	19a. Informant's Name/Relationshi		- 1	ing Address (Street a				
e, N and 2 Health em 27 ther tr		James G. Rallo-	son	20b. Place of Disp	4 Sandrin			ville, MI Oc. Location - City	
Baltimore, Dermit, Page 1 and Department of Hee Important: If item any injury or othe		1 Burial 2 Cremation 4 Donation 5 XOther (Sp		cemetery, cre	matory or other plac			Timonium	
Baltimore, Marylan permit, Page 1 and 2 should be find Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events.	5	21. Signature of Funeral Service Lie	censee William		2. Name and Addres 1050 York			Funeral 21204	Home, Inc.
Physican Medica Examine	al	23a. Part 1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aly one cause on each line		ter the mode of dyin	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
760 Key sate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	a consequence of):					
60 ate be e ohysicial the buri	edical		d						
th certific ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	ру		23d. Date of Month	delivery Day Year
S, P.O. Bours that the dear signed by the and the detached for the and	ें	Part II. Other significant conclusion	chro hi	_	underlying cause gi	ven in Part I.	23e. Did toba	\	e to the cause of death?
Division of Vital Records, tal or Attending Physician: The law 1 equires trs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be an by the funeral director, page 2 should be an order or a second the funeral director.	Completed						24a. Was an autopsy perform 1 Yes 2	prior death	autopsy findings available to completion of cause of 1? Yes 2 No
/ital R6 sician: The certificate lirector, pag	To Be	25. Was case referred to medical examiner?	Hospital:	ent 2 🗆 ER/Outpatie	_ Oth	er:	ck only one) Iome_5 ☐ Resider	ace 6 \(\tau \) Other (Sr	necity)
on of Vital F nding Physician: T tth. :: After this certifica e funeral director, p		27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of injur (Month, Day	ry 28b. Time o	of 28c. Injur	y at	28d. Describe hov		
Division all or Atters after degral Director	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e Place of this	iry - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:.	Medical	(Check 2 Medical F	Physician: To the best of xaminer: On the basis of e Nurse Practitioner: To the	xamination and/or inve	estigation, in my opini e, death occurred at	on, death occurred the time, date and p	at the time, date and place, and due to the	place, and due to to cause(s) and manne	he cause(s) and manner stated. er as stated.
To 1		29b. Signature and title of certifier	2000			315	29	July 22	2012
3		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type,	Parkall Parkall	e mo	21254		
S Regis	tate trar	21 Data filed (Month Day Year)	2012 Registra	eath (Item 23a) (Type,	ake				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 U Physician/ STEVEN RUSSEL Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death

BALTIMULE 2 4c. County of Death Examiner HOSPITAL SINAI BAUTIMOR N/A If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Min. Months Hours Director 212-48-7032 1 X M 2 □ F 08/09/1946 **ENGLAND** 65 Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral USA 3208 CAVES ROAD 21117 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner ones. Armed Forces?

1 X Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) RUSSEL AUTOMOTIVE DEALER PRINCIPAL Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ ZIPSER ADELLA RONNIE H RUSSEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELANIE STERRY/DAUGHTER 13524 MITCHELLS WAY, WEST FRIENDSHIP, MD21794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 07/24/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Superal Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Stage SYSTOIC Physician/Medical ENG Caraidmu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No for Pregnant at time of death been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 1 Yes 2 No Yes 2 No 25. Was case referred to predical 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} Hospital 1 Yes 2 No Medical Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 / Natural 5 Pending injury Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide
4 Homicide 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

only one)

3 L 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

Certifying Nurse Practitioner: to the be

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person who completed cause of death (Item 23a) (Type, Print) 1aua

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 22,2012 JULY BETTIE REUTTER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death EMERITUS ASSISTED LIVING TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 570-30-7897 1 M 2 X F 91 09/29/1920 CALIFORNIA r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2608 N. CALVERT STREET 21218 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3€XWidowed 4 □ Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 nd Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) HOUSEWIFE DOMESTIC traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ WILLIAM LYTLE ANABELL RICHARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ø MARK REUTTER/SON 2608 N. CALVERT STREET, BALTIMORE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) BAXVIEW CREMATORY 7/24/12 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility T901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ myo cara 141 Medical resulting in death) Examiner Coronny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin physician and sthe burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The lew requires that the death certificate be e attending physical as the br Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day ed by the at detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 2 🗌 No 1 Yes funeral director, Be 25. Was case referred to medica of Vital 26. Place of Death (Check only one) Hospital Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \) ASSUTED 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of spital or Attending P nours after death. neral Director: After t y filled in by the funer. Certificate: 28c. Injury at Natural N 5 Pending Division 2 Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 014 address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST TOWSON MY 6701 31. Date filed (Month, Pay Ye State 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Reins PM DOROTHY として 2012 5:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Johns Hopkins Bayview Medical Center N/A **Baltimore** 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 XF Yrs. 83 1929 MARYLAND 216-24-6760 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evant. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Directo MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 512 S. OLDHAM STREET 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ٥ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 TELEMARKETER AMVETS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER WOJCIECHOWSKI HELEN ELIZABETH MARCO ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE A. REINSFELDER/HUSBAND 512 S. OLDHAM ST., BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STANISLAUS CEM. 7/23/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING STREET, BALTO., MD 21. Signature of East Service Licensee 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** VENTRIWIAR FIBRILLATION disease or condition resulting in death) */Medical Due to (or as a consequence of): Examiner 418 Dec DSEATE 11 M3/F Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). use as the burial-tran that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate has performed 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ funeral

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this s after death. I Director: After the filled in by the

Hospital: 1X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 ☐ Accident Injury 1 🗌 Yes 2 🗌 No Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier

(check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

255 -000

29b. Signature and title of gertifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ATHSM JMD. AMBERZEN

4940 Eastern Avenue, Baltimore, MD, 21224

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2012

State Registrar

Certification:

Medical

within 24 hours 70 the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ WILLIAM EDMUND STEARNS 2012 3:30A_M 2*₽* July Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Emeritus Assisted Living of Towson Baltimore County Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min **Director** 216-09-7510 1 X M 2 🗆 F 100 Oct 6, 1911 Maryland Usual Residence of Deceder 28a-f shov 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Virginia | Prince William Gainesville 10e, Street and Number 10g. Citizen of What Country? Funeral 6280 Culverhouse Court 20155 USA 12. Was Decedent Ever in U.S. Armed Forces? 444—149 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Concrete Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Mary Agnes McGuigan Gibbons Stearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Stearns (Nephew) 6280 Culverhouse Court, Gainesville, VA 20155 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Dul Valley Mem Grdns 7/27/2012 Timonium, Maryland 21. Signat of Funeral Service is see Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ peration disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause, a ter characterying Cause (Disease or injury that initiated events resulting in death) Last Examinet Due to (or as a consequence of): attending physician and Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exec 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician an Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 2 - No filled in by the funeral director, 25. Was case referred to 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury ✓ Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practities or: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature a Hitle of certifier 29c. License number 29d, Date signed (Month, Day, Year, D24/2

DHMH 17 Rev 06-2011

State Registrar WEST

nd address of person who completed cause of death (Item 23a)

ROSENBER

32. Registrar's Signatur

BRUCE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RANDALL L. SCOTT July 14^{ay} 2012 7:40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 9/19/1956 ou*ntry* WV 193-46-3521 55 Director 1 🗶M 2 🗆 F Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** PA York Delta 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 1000 Front Street 17314 USA Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Yes 2XXIII 1 Never Married 2 X Married 1 Yes 2 X No Specify Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetr. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Mechanic Auto Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James L. Scott Betty Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie A. Scott/Wife 1000 Front Street, Delta, PA 17314 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🏋 Cremation 3 🗆 Removal from State Evans Eagle Cre. 7/17/12 Leola, PA 4 Donation 5 Other (Specify) Signature of Fone/al Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examina?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

M COCO TOO S Division of Vital Records, P.O. Box 68760 n 24 hours and ne Funeral Director; A within 2 To the 1

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) Fifer hosaheake Dr. Bel Air mid 31. Date filed (Month, Day, Year, JUL 2 5 2012 State Registrar

29a. Certifier

(Check

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sto Kes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Me 101 ta 0, **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 27, 1934 9. Birthplace (State or Foreign Months Min. Director 218-28-8415 78 1 □ M 2 □XF MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 N. Wolfe St. 21231 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) (LPN) yrs Nurse Johns Hopkins Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Wilkins Josephine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $Apt. \\ 4912$ Crenshaw Ave. Baltimore, Md 21206 Wanda Williams (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State July 26,2012 Loudon PK. Balto, Md 4 Donation 5 Other (Specify) Service Licen, ee Calvin B. Scruggs Funeral Home <u>1412 E.</u> Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Malignancy disease or condition resulting in death) - tumors Medical Due to (1) as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician al s the burial-1 Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 W Unknown certificate has been si rector, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death?
1 Yes 2 No perform the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other; 4 Nursing Home 5 Residence 6 Other (Specify, ျှ 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after des To the Funeral Directo completely filled in by the Suicide Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carolyn Piescia Kramer

31. Date filed (*Month, Day,* Year) **JUL 2** 5 2012

RES-000

1800 Offean st.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Denise Marie Sirbaugh 2012 P.M9:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care Towson Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 215-64-9853 Months Days Hours (Month, Day, Year) Director 1 🗆 M 2 🖺 F 59 Yrs June4,1953 Maryland Usual Residence of Decedent filed within 72 hours over tal Hygiene.
ad other then "neturel", or Items 23a or 28a-f show e event, the Medical Exa., in a must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 ☐ Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 812 Jaydee Avenue 21222 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Taylor Juanita Roach should the and Merits mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si of Health a item 27 l Aaron Bryan - Son 641 S. Lakewood Avenue Baltimore, Md.21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pege 1 and Department of Information of Informatical Items and Informatical Information of the Bright State of the Information of the Info Ju1 vate Purial 2 Cremation 3 Removal from State Oak Lawn Cemetery! 25,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility aczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ PAncretic disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir certificate be executed Cause (Disease of injury that initiated events attending physician end for use es the burlal-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown the 9 Unknow P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 this certificate has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Division of Vital director, Be 26. Place of Death (Check only one) Hospital: Other: 2 X/No 1 Tes ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) No Sylly 28a. Date of injury (Month, Day, Year) Hospital or Attending PI
 24 hours after death.
 Funeral Director: After the letely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 Char N. Charles ST TONSON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 31. Date filed (Month, Day, MD) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Maurice Upton Tur	1	- For State	ate of Ma	yland /			Health and Death	d Menta	al Hygiene	Pag No.	201	2 2352
Physician	7	e gistrar I. Decedent's Name (First, Midd	le,Last)						2. Date of De Month		ear	3. Time of Death
Medical Examine	_	Ma. la. Facility Name (if not institution	urice	Uptor	n Turr				July 14,	2012		1503 hrs
	Í	a. Facility Name (if not institution 2125 Benson Mill Roa		a number)			4b. City, Town, or Sparks Glei		Death	4c. County Baltime	ore Cou	
Funeral	5	5. Social Security Number	6. Sex	7. Age	(In yrs. last b	irthday)	If Under 1 Yea	r If Under	24Hrs. 8. Date of	Birth (MM/DD/YY)	YY) 9. Bir	thplace (State or
Director		213-28-3649	1 X M 2	F	83	Yrs	Months Day	s Hours	Min. 09/0	4/1928	Foreig Co	ountry) MD
A		Usual Residence of Decedent Oa. State 10b. County			10- 0't T-							
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or ite		1 Never Married 2 X M	1X Y	es 2[No				-uerto Rican, etc.)		ite, etc.	-1.1.
ural",	3	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give or Dates:			Deceden	Yes 2 X No		nd of work done	Specify 16b. Kind of E		White
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215-0036 be filed within 7 and Hygiene. rked other than ent, the Medica	3 1	7. Father's Name (First, Middle							Name (First, Middle		ie)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3	Clarence Tul 9a. Informant's Name/Relations	cnbaugr ship (Type, Print)	1	9b. Mailing	Address (Stree	t and Numb	ie Daile er or Rural Route N	ey umbe _i , City or To	wn, State	e, Zip Code)
MD dd 2 sho		Eric R. Turi	nbaugh	/ So	n 4	1007	Church	Rd.,	, Manche	ster,	MD 2	21102
MOFe, Pages 1 and rent of Heal nut: If iten	[2	20a, Method of Disposition 1 Burial 2 X Cremation	3 X Remov	al from Stat	20b. Place crem	of Dispos	ition (Name of cer ner place) a tion		Date	20c. Location	1 - City or	Town, State
imo Page ment c	L	4 Donation 5 Other S	pecify:		Dir	cect	Servic	е	July 26 2012	' Y	or <u>k</u>	, PA
Baltil Permit. Departm Imports injury o	2	1. Signature of Funeral Service	Licensee	/					J Harten			
Physician		3a. Part I. Enter the disease, or		at caused t	he death. Do							PA 17349 Approximate Interval
/Medical	١,	failure. List only one cause mmediate Cause (Final disease	Adlance	clerotic C	ardiovasc	ular Dis	ease					Between Onset and Death
Examiner		or condition resulting in death)		as a conse								
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ox 68760, eath certificate be executed attending physician and for use as the burial - transit		UNPENDED	AMEND	ED								
6876(ertificate ding physe e as the b	2:	F FEMALE: 3b. Was decedent pregnant in t		es, outcom ve birth	e of pregnanc	_	tal death 3	Ectopic p	pregnancy	23d. Date		y Day Ye ar
Box 6876 e death certificate the attending phy ad for use as the l hysician/M	2	past 12 months? 1 Yes 2 No 9 Un	4 P	regnant at t	me of death	2	ner (Specify)					,
). Box 6 the death cent by the attend scheed for use		Part II. Other significant condi	a 0	nknown	hut not resulti	ng in the u	inderlying cause g	iven in Part	1 23e. Dio	topacco use con	tribute to	the cause of death?
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Records, The law require ficate has been signage 2 should be					·			-	24a. Wa	as an 24b		topsy findings available completion of cause of
eco he law ate has age 2 s									per	formed?	death?	
Division of Vital Records, tal or Attending Physician: The law requirers after death. **A Director: After this certificate has been sited in by the funeral director, page 2 should be entification: To Be Completed		25. Was case referred to medical examiner?					26. Place		check only one)			
f Vidential Control of the Physics of Top F	2 -	1 Yes 2 No	Hospital: 1	Inpatien		Outpatient			Nursing Home 5	Residence 6		r: Scene
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ivisior or Attencather death Director: I in by the	5		stigation 28e.	Place of Inju	ıry - At home,	farm, stree	et, factory, office b		28f. Location		ber or Ru	ural Route Number, City
Division o spiral or Attending tours after death. The filled in by the function: Certification:		outdoo	mined (Spe	cify)					or Town	, State)		
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tweedical Certification: To Be Completed by Physician/M.			miner:On the ba	sis of exam					e, and due to the ca urred at the time, da			
To To	2	9b. Signature and title of certific		er stated.			29c. Licens	e number	<u> </u>	29d. Date sig	ned (Mo	nth, Day, Year)
		Drul					O.C.I	M.E.		July 15, 2	012	
101	3	0. Name and address of person					\// Daltimas	Stroat 5	Politimara AAD (11222		
State	e 3	Donna M. Vincenti, M			al Examine s Signature	1 900	vv. Dalumore	Street, E	Baltimore, MD 2			
Registra		ULate 205 M 2012 V, Year	neur	A. 1	racket					_		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ July 20ÎŽ 8:20 Рм Linda Sue Tartal Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Lutherville 8506 Marblehead Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8 Date of Birth **Funeral** Hours Min 218-58-1180 Director 1 □ M 2 🕅 F Mar. 24, 1953 Maryland 59 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 😾 No MD Kent Chestertown 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 21620 241 Devon Drive "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white 3 Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Underwriter Mortgage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Constance Sacker James Milford Todd, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Furnace Court; Hunt Valley, MD 21030 Michael A. Tartal husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 XBurial Cremation 3 Removal from State Dulaney Valley Mem Gardens 17/26/2012 Timonium, MD 5 Other (Specify) 1050 York Road 21. Signature of 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or comp Approximate Interval Between shock, or heart failure. List only q Onset and Death Immediate Cause (Final BRADT Physician/ disease or condition resulting in death) MITASIA TO Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death eral Director: After this certificate has been signed by the sfilled in by the funeral director, page 2 should be detached 1 ☐ Yes ∠ ... 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death?
1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 15-(nw) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 To Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year) 2+,2012 20018320 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

1075

31. Date filed (Month, Day, Ye

ROAD

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32. Registrar's Signature

71 21093

John rem

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Homer Gordon Thomas 0531 A 012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore N/A 05 DITU Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 219-18-8119 **Director** 1 X M 2 🗆 F 87 Dec. 28, 1924 Maryland Usual Residence of Decedent or items 23a or 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Completed by Funeral Director MD. Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 6802 Ridgewood Road USA 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", Special nite 3 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, the Menone. College (1-4 or 5+) Elementary/Secondary (0-12) Board of Education Guidance Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gordon Clinton Thomas Lunonia Alice Jackson hamas, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Thomas/ Wife 6802 Ridgewood Rd. Baltimore, MD. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 7-23-12 Hilltop Service Co. Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204 21. Signature of uneral Service De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final with brain Physician disease or condition Medical resulting in death) years **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last nding physician a use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending newsimis. Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tyes 2 X No ER/Outpatient 3 DOA Inpatient 2 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

only one

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

5 2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2017 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Raltimore | S. Date of Birth (Month, Day, Year) | Mar8, 1949 5. Social Security Number 219 – 50 – 6655 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 63 Yrs. If Under 1 Year 6. Sex **Funeral** Days 1 □ M 2 TVF Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 X No Director Baltimore Dunda1k Md. 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21222 U.S.A. 1962 Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) County Schools Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theresa H. Kwarta John D. Sufczynski 19a. Informant's Name/Relationship (Type. PrintDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2976 Raking Leaf Drive Abingdon, Md.21009 Nicole Jennifer Travagline 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) $July^{\frac{Date}{y}}$ 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 24, 2012 Baltimore, Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M00933 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md.21222 M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last ician and burial-tran Due to (or as a consequence of) physician as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical as g Bulbt IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the att 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ Yes 2 No page 2 has The 2 No 1 ☐ Yes 1 ☐ Yes certificate Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital: 1 Mnpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ည this funeral 27. Manger of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural ne Hospital or Attendin n 24 hours after death. e Funeral Director; Aft pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000

DHMH 17 Rev 1/2001

State

Registrar

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4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 PerPhy G929 7/25/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201/2 Month July 6:40 PM Physician/ WOH Bernard 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 062-20-3043 Director 1 ፟ M 2 □ F 84 03/26/1928 NY 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b Count er than "natural", or Items 23a or 28a-f sho with the Maryland Directo 1 ☐ Yes 2 X No SAN DIEGO SAN DIEGO CA 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Funeral USA 92115 5086 COLLEGE GARDENS COURT Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hyglene. ant. If item 27 Is marked other than "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 🎽 No Specify: Baltimore, Maryland 21215-0036 3 ☑ Widowed 4 ☐ Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT Ith and Mental Hygie 27 Is marked other treumetic event, e 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ GOLDSTEIN LEAH WOLF TRVTNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2118 HERITAGE DRIVE, BALTIMORE, MD 21209 LESLIE WOLF PLAJZER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it 1 X Burial 2 Cremation 3 Removal from State ត 07/22/2012 REISTERSTOWN, MD injury BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign ture of Funeral Service Licensus 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition prostate (ancen Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funaral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical #人 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death g 🗌 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Certificate: To Be Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ent hospice 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound to the second 29a. Certifier The basis of examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

Sky pain(MV) 29c. License number 29d. Date signed (Month, Day, Year) 20057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 s 203 NSRAJAPAKSEMD 2835 Smith A

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

		-	For State Registrar	tate of Maryland / L	Certificate o			eg. No.					
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death				
and the same	Medic	al	Roy Wilfo 4a. Facility Name (if not institution, give stree		4b City Town	, or Location of Death	puly 23,	4c. County of Deat	4:00 AM M				
زر	Examin	er	Crescent Cities Co		River			Prince George's					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Ye Months Da		8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)				
	Director		236-26-3741 1 K M Usual Residence of Decedent	2 □ F 85	Yrs.		Sept 20,	, 1922 Se	well, WV				
	and show	ro	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits				
	Maryf 28a-f otifie	Director	MD Prince Geo	orge's Berwy	n Heights				1 ☑ Yes 2 ☐ No				
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", are items 24 or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 6004 Osage Street		10f. Zip Cod			0g. Citizen of What Co	untry?				
	death r item ner m	Fur		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
936	s after al", or Exami	d by		1 🛣 Yes 2 □ No If Yes, Give Year or Dates.	1 □ Yes 2 🛣	No Specify:		Specify: Wh	ite				
Maryland 21215-0036	hour hatur	Completed	15. Decedent's Educat (Specify only highest grade c	ion 16a.	Decedent's Usual Oc	cupation ne during most of work	ina	16b. Kind of Business/	Industry				
12	thin 72 ne. than '	om		College (1-4 or 5+)	life. DO NOT use retir	ed)	ang	Federal G	overnment				
0 0	ed wit Hygie other ent, th	Be (17. Father's Name (First, Middle, Last)	4 011	- Chilear Bire		ne (First, Middle, N						
<u>lan</u>	l be fil fental rrked tic ev	2	Elmer Wilfong				(Unknown)						
lary	should be filed what and Mental Hyg 7 is marked other traumatic event,		19a. Informant's Name/Relationship (Type, I		City or Town, State, Zij								
<u>ک</u>	and 2 seedth		Robert Charles Bake					lghts, MD 2					
Baltimore,	Page 1 ament of H ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cemeter	Disposition (Name of y, crematory or other politan Ci	olace) cematory 7-		20c. Location - City or Town, State Alexandria, VA					
Balti	permit. Page 1 and 2 should be fi Department of Health and Menta Important. If item 27 is marked any injury or other traumatic e once.		21. Signal are of Funeral Service Licensee	101	22. Name and Ad	dress of Facility	[etropoli	itan Funera Alexandria,					
			23a Part 1. Enter the disease, or complicat	ons that caused the death. Do no	ot enter the mode of o				Approximate				
	Physician .	8	shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	Atherus	clora hic	Cardio	vascula	y disen	Interval Between Onset and Death				
	Medical Examiner		resulting in death) Due to (or as a consequence of):										
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to or as a consequence o	of):								
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7,	icate be executed j physician and is the burial-transi	ia E	resulting in death) Last	Due to (or as a consequence o	11).								
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89 2	eath certific attending p I for use as	an/N	23b. Was decedent pregnant	If yes, outcome of pregnancy	3 ☐ Ectopic pregr	nancy		23d. Date of de	,				
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours attendeath. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/Medical		4 Pregnant at time of death 9 Unknown	5 Other (specify			Month	Day Year				
P.O	s that the gned by be deta	by	Part II. Other significant conditions contrib	uting to death but not resulting in	n the underlying cause	e given in Part I.		pacco use contribute to	191.2				
rds	equire leen si hould	eted					1 LJ Ye		robably 4. Unknown topsy findings available				
eco	e has b	Completed					autops perfori	prior to death?	completion of cause of				
a H	an: Th	Be C	25. Was case referred to medical		26	6. Place of Death (Chec	1 L Yes :	ZILINO] ILIYE	2 🗆 NO				
ξ	hysici his ce al direc	70 E	examiner? 1 Yes 2 No Hosp	1 Inpatient 2 ER/Ou	tpatient 3 L DOA	Other: 4 Nursing H	ome 5 🗆 Reside	ence 6 Other (Spec	ify)				
Division of Vital Records,	ding P th. After the	Certificate:	1 Natural 5 Pending		njury V	njury at vork? Yes 2 No	28d. Describe ho	w injury occurred					
isio	· Atten er deal ector: by the	ertifi	3 Suicide 6 Could not be	28e. Place of Injury - At home, far building, etc. (Specify)			28f. Location (St. City or Town	reet and Number or Ru	ral Route Number,				
<u>S</u>	nital or urs aft ral Dir illed in												
	e Hosp 24 hor e Fune letely f	Medical	(Check 2 Medical Examiner:	n: To the best of my knowledge, on On the basis of examination and/or actitioner: To the best of my know	r investigation, in my o	pinion, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.				
	To the vithin To the comp	2	29b. Signature and title of certifier		29c. Lic	ense number	2	9d. Date signed (Mont	h, Day, Year)				
				n P	000	06010		0+-2	572				
	5		30. Name and address of person who comp	BLUD E		Albuin 1	n 16 /	77-2					
F	Sta Registra		31. Date filed (M2tr Day Year)	32. Registra 's Signature	4								

Physician/ Medical **Examiner To the Hospital or Attending Physician**: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

the burial-transi attending physician signed by the attending pd be detached for use as funeral director, within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

notified

ms 23a or must be n

Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu

Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Certificate: To Be Completed by

Medical

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending
Investigation work? 1 ☐ Yes 2 ☐ No Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of

10062634

JULY 22, 2012

MATEEN 31. Date filed (Month, Day, Year) State Registrar

HICKORYRIBGE 20 COLUMBIA MO 21.44 10796 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 8:19 P M LAWRENCE WELLS JULYMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Min Months Hours Director 233-56-8875 1 X M 2 - F 77 SEPT 11 1934 WEST VIRGINIA Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified HYATTSVILLE 1X Yes 2 ☐ No MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 USA 7715 MUNCY ROAD ıral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than 'e event, the Me Elementary/Secondary (0-12) 12TH College (1-4 or 5+) PRIVATE Health and Mental Hygiene. BAKER ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THOMAS WELLS EMILY HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES V. WELLS/ WIFE 7715 MUNCY ROAD, HYATTSVILLE, MARYLAND 20785 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 07/30/2012 | CHELTENHAM, MARYLAND MD VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME INC. Japhney 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 23a. Part 1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Multiple organ dystunction Ptrysiction/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury Ducito (or as a consequence of): bacteremin Klebsiella Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Yes 2 No 9 Unknown ned by 1 Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signed page 2 should be dechist 1 Yes 2 No 3 Probably 4 Unknown Coronary artery 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate l 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\supseteq\) Residence 6 \(\supseteq\) Other (Specify) Hospital: ိ Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation within 24 hours after deatl

To the Funeral Director.,
completely filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29d. Date signed (Month, Day, Year) D00 43662 DO0 43662 July 19,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William PG Hospital 15040

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sarah Ann Whitfield Physician/ 24, 2012 8:45 A.M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville 445 Kent Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min. 228-20-8618 Director 1 ☐ M 2🗓 F Oct. 1923 88 Virginia Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? USA 10e. Street and Number 21228 445 Kent Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Proof Reader Insurance Be 7. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Surname) Edna Earl Doughty Simpson Drummond မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Kent Avenue; Catonsville, MD 21228 Husband James T. Whitfield 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 1 Durial 2 Cremation 3 Removal from State 7/26/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Lice ee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Denenti Physician/ disease or condition resulting in death) arkinson years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month Year Pregnant at time of death Yes 2 No g Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has be director, page 2 s autopsy performe 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 ♣No Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\mathbb{\mathba\mathbb{\mathba\\\\\\\\\\\\\\\an\and\mathbb{\mathbb{\mathbb{\mathbb{\mathbb{\mathbb{\mathbb{\mt 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 n 24 hours after death. e Funeral Director: A bletely filled in by the fi within 2 To the F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 4/1 0/d -rederick Rd 5 fe 20 31. Date filed (Month, Day, Year, JUL 25 2012 State Registrar

3 🗌

32. Registror's Signature Sark

Medical

29a. Certifier (Check

only one)

29b. Signature and

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18ay 20Ï2 Weddington Elizabeth 8:06p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 90 Director 212-22-8394 1 □ M 2X ☐ F 02 17 22 DC ral", or items 23a or 28e-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 □ No MD NA 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A. 21244 8337 Liberty Road death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🔀 No If Yes, Give within 72 hours after Maryland 21215-0036 Black 1 Yes 2 No Specify: "natural", Specily: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Custodian 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Beatrice Bailey Wayman Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Md 21133 9208 Bengal Road, Randallstown, Barbara Cooper-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Description 1 Description 2 Description State 4 Description 5 Description 5 Description 5 Description 1 Descript 7/27/2012 Donation 5 Other (Specify) Arbutus Memorial Arbutus, 21. Si matu e pf Funeral Service Licensee 22. Name and Address of Facility March F7H West 21215 Baltimore, Md 4300 Wabash Ave, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart calure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between SMOKE Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **≜**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ettending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) signed by the el P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 1 Tes 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: within 24 hours after death.

To the Funerel Director; After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPIC Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Escritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 3303 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles HARLUES Touson un NORA 610 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type of Print Parack Indelibie Ink. Engline All Copies Are Legible.
State of Maryland Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201-75 PM White U. Roslia Medical 4b. City, Town, or Location of Death Randallstown 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Season's Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min. Country) 09 Director 219-30-4043 79 09 1 M 2X F r items 23e or 28e-f show instraust be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21216 2714 West Lanvale Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. 1 Never Married 2 ☐ Married Š $_{Specify}$ B1ackBaltimore, Maryland 21215-0036 "natural", o 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12)
9th grade College (1-4 or 5+) Page 1 and 2 should be filed within Private Domestic na other Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked oth any injury or other treumetic event ones. 17. Father's Name (First, Middle, Last) Mary Hightower 2 Nelson White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4022 Walrad Street, Baltimore, Md Delores Armwood-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/17/2012 Arbutus, Arbutus Memorial March Address of Facility 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ather sclerots disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) ours after death. erai Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2. No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2- No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1-C certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 590 m m State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death BACT OSP TNORE N N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F 10730/1929 217-26-1782 MARYLAND 82 **Director** Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Examiner must be notified at Director 28a-f MD N/A BALTIMORE 1 X Yes 2 No 5 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 111 N. KENWOOD AVENUE 21224 U.S.A. or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: WHITE 3X Widowed 4 □ Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR STATE OF MARYLAND 4 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, <u>ہ</u> JOESPH TORRE MARY FERICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA DOBRY/SISTER 113 N. KENWOOD AVENUE, BALTIMORE, MD 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 7/22/12 BALTIMORE, MARYLAND 21. Signature of Fune 22. Larlard Address of ETLER INC FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final 4 NLER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inversid rifector, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown Completed 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one a title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year)

∫5√ State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

2. Registrar's Signature

erson who completed cause of death (Item 23a) (Type,_Print)

B. parker

MORE

20215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day DANIEL ZERDEN JULY 2012 07:50A M Medical. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE . Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Birthplace (State or Foreign Country) Months Days Hours Min (Month, Day, Year) Director 217-18-0707 1 X M 2 D F 89 Usual Residence of Decedent 08/02/1922 27 is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A1 X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7121 PARK HEIGHTS AVENUE, #408 21215 1 end 2 should be filed within 72 hours after death wif Heelth end Mentel Hygiene. Item 27 is marked other then "neturel", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL MERCHANT WOMENS APPAREI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY ROSENBERG ZERDEN SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER ZERDEN / WIFE 7121 PARK HEIGHTS AVENUE, #408, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 e
Department of H
Importent: if ite
eny injury or ot Date cemetery, crematory or other place)
ANSHE EMUNAH —
ATTZ CHAIM CONG. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/24/2012 BALTIMORE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Vascular Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) cate has been signed by the ettending physiclan end page 2 should be detached for use as the burlal-transit or Attending Physicien: The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? After this certificate the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 **W**No Other: 4 Nursing Home 5 Residence 6 Yother (Specify) in Pah at ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 🗌 Pending within 24 hours efter death.

To the Funerel Director: A completely filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Varmora Mille MO D 4.7683 21/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Millo SOX PO 1525 21117 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month-Physician/ 7:05AM July Josephine Loretta Ardinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney Keedy Nursing Home Washington Boonsboro 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Funeral Months Days Hours Min. 219-20-3102 86 1 □ M 2XXF Director 25, 1925 Maryland Dec. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8507 Mapleville Road 21713 USA "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Lorretta Andinger Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: White 3√X Widowed 4 □ Divorced Year or Dates Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. Housewife Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Elizabeth Williams Resley Ellsworth Speaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Smithsburg, MD 21783 Carolyn S. Smith - Daughter 11861 Wolfesville Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o 1 \(\) Burial 2 \(\) Cremation 3 \(\) Removal from State 4 \(\) Donation 5 \(\) Other (Specify) OSEPHINE 07-16-2012 Williamsport, Maryland Greenlawn Mem. Park 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Juneral Service 425 S.Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cong Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performe is certificate h 2 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Z 2 No ည vursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ractitioner: To the best of my knowledge d at the time. Jute and place, and due to the cause's and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Arundel Linthicum Heights Tate House 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Days Months Hours Director 109-24-5567 1 X M 2 🗆 F 80 Brooklyn, NY Yes Sept.18,1931 nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland settment of health and Mental Hygiene. orderst: If item 27 is marked other than "neturel", or items 23a or 28a-f show orders: If item 27 is marked other than "neturel", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b Count 10c. City, Town or Location Director 10d. Inside City Limits MD Howard 1 X Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2641 Queensland Dr. 21042 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 X Yes 2 No
If Yes, Give
Year or Dates. Korean Black White etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify White 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Service Industrial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Sylvia Sherman Ada t.o Max 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Burn Route Number City, Town, State Zip God) 2641 Queens land Dr., Ellicott City, MD 21042 Roberta Adato / spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park July 10,2012 Elkridge, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licenses 254 Carroll St. NW. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ FELD. KUB disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physician and for use as the burlal-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) Month ed by the e 9 T Unknown Records, P.O. ate has been signed I page 2 should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes - No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The i within 24 hours after death.

To the Funeral Director After this certificate h completely filled in by the funeral director, page performed 2-1 N 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/ No Other: 4 Nursing Home 5 Residence ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes Investigation 6 Could not be 2 No 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and the of certif 31. Date filed (Month, Day, Year, State 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Herbert Edmund Adami 28 2012 6:10 P June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Westminster Golden Living Center 8. Date of Birth (Month, Day, Year) Mar. 4, 1922 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 213-30-4782 Mar. Germany **Director** 1 🔀 M 2 🗆 F 90 "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Westminster Maryland Carroll County 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 United States Funeral 1234 Washington Road death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ☐ Yes 2 X No Yes, Give þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene.
77 is marked other than "nature traumatic event, the Medical. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) dry cleaning dry cleaner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette Frohlich ဂ August Adami permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7440 Flamewood Drive Clarksville, Maryland 21029 Edmund G. Adami / son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 29, 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Carroll Cremation Hampstead, Maryland 2012 4 Donation 5 Other (Specify) Eline Funeral Home 21. Signature of Funeral Service Lice is 22. Name and Address of Facility Tures Hampstead, Maryland 21074 934 South Main Street M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician .5C DAOVA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine CVD or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year n signed by the a lid be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, has been sig ge 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 🗆 No certificate 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Certificate: (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29 ROUGTOT 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jacqueline Hearn, C.R.N.P. 688-C Poole Road Westminster, Maryland 21157 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

JUL 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lemuel Paul Adams, Jr. SO PM Medical 4a. Facility Name (if not institution, give street and number) of Death 4c. County of Death 4b. City. Towr **Examiner** Medica lato Birthplace (State or Foreign Country) If Unde If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Months Hours Min 220-16-4207 Director 1 ★ M 2 □ F 25, Sept. 1925 Maryland 86 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location notified at Director 1 🗆 Yes 2 💢 No Maryland Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o must be items 23a Funeral 4215 Piper Lane 20658 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner ed Forces? Yes 2 No 1 Never Married 2 Married 1X Yes 2 □ No If Yes, Give Year or Date þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien

7 is marked other traumatic event, the Produce Manager Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ other traumatic Lemuel Paul Adams, Sr. Lillian Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Wife Peggy M. Adams P.O. Box 302, Marbury, Md. 20658 20b. Place of Disposition (Name of cemetery, crematory or other place) July 11, Date 2012 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Waldorf, Maryland Donation 5 Other (Specify) Trinity Memorial Gardens 21. Signature of Fun ral S 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Md. disease, or complications that caused the death. ailure. List only one cause on each line. Approximate
Interval Bc ween
Onset an \(\)\(\) eath and enter the mode of dving, such as cardiac or respiratory arrest un Agentocler own Immediate Cause (Final SPIRATION WOUNDWIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform Yes 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 Appatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending iniury 24 hours after death.
Funeral Director: A Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Fune completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractification for the basis of my browledge. See the commod at the time, date and place, and due to the cause s) and manner as stated (Check the 29b. Signatu and title of certifier 29d. Date signed Month, Day 262 5 d address of X State 1 0 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 7:20 PM Physician/ July KAMIL 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CREEK MONTGOMERY NURSING JAKOMA ENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Mi 9. Birthplace (State or Foreign Country) TRINID AD TOBACO 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 🗷 M 2 □ F Months 577.76.7528 Director Usual Residence of Decedent of Health and Mental Hygiene. riem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MONTGOMER TAKOMA 10g. Citizen of What Country? 10e. Street and Number Funeral TRINIDAD + TOBAGO 20912 ARROLL Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ò Specify: EAST INDIAN Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 4 Yrs . Elementary/Seconday (0-12) ELECTRICAL ENGINEER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic eve MOON WAJID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROAD ROCKVILLE - MD AU MOHAMMED-DAUGHTER 513 PINEWOOD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

MD NATIONAL LEMETERY 20c. Location - City or Town, State 20a, Method of Disposition LAUREL MARYLAND 1 K Burial 2 Cremation 3 Removal from State 7/4/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility HUSSAIN'S ISLAMIC FUNGRAL SERVICES 21. Signature of Funeral Service Licensee mo 1388 2150 LANHAM SEVERN ROAD LANHAM, MD-20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD INSTANT Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy
☐ Other (specify) Month Year in the past 12 months? Day Pregnant at time of death 2 No signed by the a I be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STROKE 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy page 2 s 2 🔀 No DEMENTIA 1 🗌 Yes certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work' 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) GROVE ROAD #130 ROCKVILLE SHADY 245 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 10:30P^M 2012 28 Valeria M. Adams Tune. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1800 Palmer Road #205 Fort Washington Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 579-74-7116 Director 1 M 2 X F March 18,19**2**6 86 Wash.,DC show 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f 1 X Yes 2 No MD PG Fort Washington 10g. Citizen of What Country? 0 10e. Street and Number ral", or items 23a o Examiner must be Funeral 1800 Palmer Road #205 20744 United States death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. , or Yes 2 XNo Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3X Widowed 4 ☐ Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) d Mental Hygiene. Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ of Health and Ment fitem 27 is marked other traumatic e McKinley McMahon Nannie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5224 5th St., NW Washington, DC 20011 19a. Informant's Name/Relationship (Type, Print) Kathleen Blocker/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 7/6/12 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nat Harmony Mem. Park Landover, MD f Funeral Service Licensee 21. Signature 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock Immediate or heart failure. List only one cause on each line. Onset and Death Cause (Final Metastatic Cancer of Pleural Unknown Primar Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 perforn 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: / completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office pullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the only one)

Registrar

29b. Signature and title of

30. Name and address of ne

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DHMH 17 Rev 06-2011

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completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number DC 12230 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 28b, 28f, per me, g930 8-14-12 sm. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathbf{Julv}^{\mathsf{Month}}$ 2012 John Martin Barun 5:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours Director 523-38-9750 1 **X** M 2 □ F Yrs. 77 Dec. 18, 1934 Colorado Usual Residence of Decedent 23a or 28a-f show ist be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must 20878 13105 Brandon Way Road United States or items "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Armed Forces? 1 X Yes 2 \(\subseteq No \) 1954-If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1957 Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Account Manager Aerospace 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Marco Barun Josephine Logar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13105 Brandon Way Road, Gaithersburg, MD 20878 Patricia Ann Barun/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 07/10/2012 Barnesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Intracerebral Bleed disease or condition Medical resulting in death) Due to (or as a consequence of): one Examiner Post Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by skull fractures cerial Records, 1 Yes 2 No 3 Probably 4 Unknown ficial factives . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Marient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pi 24 hours after death. Funeral Director: After the 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 No 5 Pending injury Natural 2 Accident 6 30 2012 Investigation unknown 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13105 Brandon Way 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Gaithersburg, MD. hane Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centrying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot) 7525 Greenway Center Drive, Said A. Daee. M.D., Greenbelt 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registrar Ш

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month 6, 11:45 A M July Myrtle Irene Burdette Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 5200 Buffalo Mount Airy Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min. **Director №** 2 **X** F 212-50-7787 97 April 29,1915 Maryland Usual Residence of Decedent 28a-f show 10b. County event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Carroll Mount Airy 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5200 Buffalo Road 21771 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2 No hours after Maryland 21215-0036 1 ☐ Yes ∠ If Yes, Give 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced "natural" Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic Harry M. Roderick Eula Norwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 Buffalo Road, Mount Airy, Maryland 21771 Shirley Burdette, Granddaughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Other (Specify)
 Other (Specify) 07/11/2012 Pleasant Hill Cem. 4 Donation Monrovia, Maryland 21. Signature of Juneral Sen Name and Address of Facility Molesworth-Williams, P.A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 once M01393 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death .Physician/ Years Hypertensive Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 d. attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year the 9 Unknown 9 Unknown s been signed by tl 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I hours after death.

uneral Director; After thely filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b Medical Certifying Physician: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a Certifier d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one

Robert

31. Date filed (Month, 194) Year)

L.

29b. Signature

Certifying Nurse P

Kaufman

tioner: To the best of my k

32. Registrar's Signature

residen

M.D.,

cause of death (Item 23a) (Type, Print)

owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) July 9,

2012

29c. License number

D13971

300 West 9th Street, Frederick, Maryland 20872

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			_ State	ryland / Depa Cen	irtment of H tificate of D							
			Registrar 1. Decedent's Name (First, Middle, Last)	Oen	incate of L	,eatri	2. Date of Deatl		3. Time of Death			
	Physicia Medio		Erma McCready Breeden				July 6, 2012 Year 9:40 P					
	Examin	er	4a. Facility Name (if not institution, give street and number) 1715 Sollers Wharf Road		4c. County of Calver							
	Funeral			(In yrs. last birthday)	Lusby If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1 9	. Birthplace (State or Foreign			
e i	Director			39 _{Yrs.}	Months Days	Hours Min.	(Month, Day, 01/23/1		(aryland			
	and show	ğ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation		01/10/1		10d. Inside City Limits			
	Maryl 28a-f otifie	Director	4	Lusby					1 ☐ Yes 2 🌠 No			
	ith the 23a or st be r	ralD	10e. Street and Number 1715 Sollers Wharf Road		10f. Zip Code 20657			0g. Citizen of Wha United S				
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at , the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ev		/as Decedent of His	spanic Origin? (Spe	cify Yes or No-		American Indian,			
36	after d II", or i xamin	by	1 ☐ Never Married 2 ☐ Married 3 文 Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 文 N If Yes, Give	0	Yes, specify Cubar	Specify:	rican, etc.)	Black, \ Specify:	White, etc.			
21215-0036	hours natura sical E	Completed	15. Decedent's Education	16a. Decede	ent's Usual Occupa	ation		16b. Kind of Busin				
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_	filed within all Hygiene. d other thar event, the M	Be C	12 17. Father's Name (First, Middle, Last)	Posta	al Clerk	18. Mother's Name			OTTICE			
ylan	d be fi Mental arked atic ev	ပ္	John Edward McCready				iolet Hu					
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	8	19a. Informant's Name/Relationship (Type, Print)			nd Number or Rura						
	f and f f Healt item 2 other		Patti Breeden Smith - Daugh 20a. Method of Disposition	20b. Place of Dispos	sition (Name of			20c. Location - Cit	and 20657			
Baltimore,	Page nent o ant: If iry or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	st. Paul (atory or other place UMC Cemet	e) :	1	Lusby, M	-			
Balt	permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licensee		Name and Address	s of Facility R			ome, P.A. 0657			
П			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.						Approximate Interval Between			
-	Medical	r h	Immediate Cause (Final disease or condition resulting in death)	OBSTRUCT	TIVE T	ULMONA	RY D	NEAGE	Onset and Death			
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s, P.O.	v requires that been signed k should be det	by	Part II. Other significant conditions contributing to death but	not resulting in the un	iderlying cause give	en in Part I.			te to the cause of death?			
ord	requii	Completed					24a. Was an		e autopsy findings available			
Rec	The law ate has page 2	Comp					autopsy perform 1 \(\sum \) Yes 2	prior ned? deat	r to completion of cause of			
tal	Physician: this certifica	Be	25. Was case referred to medical examiner?			ce of Death (Check		98,110	100 2 2 110			
of Vi	r this ceral dir	e: To	1 ☐ Yes 2 🗶 No 1 ☐ Inpatien 27. Manner of Death 28a. Date of injury	t 2 ER/Outpatient 28b. Time of	3 DOA Other	4 ☐ Nursing Hor	ne 5 X Resider	ce 6 Other (S	Specify)			
on (ending eath. or: Afte he fun	ficat	1 X Natural 5 ☐ Pending (Month, Day, 12 ☐ Accident Investigation	√ear) injury	work?	res 2 □ No	. 500011301104	injury occurred				
Division of Vital Records,	cal or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (- At home, farm, stree Spec <i>ify)</i>	et, factory, office	2	28f. Location (Stre City or Town,		Rural Route Number,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 1 XCertifying Physician: To the best of machine (Check only one) 1 XCertifying Physician: To the basis of examiner: On the basis of examiner: To the basis of examine	mination and/or investi	gation, in my opinior	n, death occurred at	the time, date and	place, and due to	the cause(s) and manner stated.			
	To the with Com		29b. Signature and title of certifier A T Mins. M	7	29c. License	- 1		d. Date signed (M				
Ţ	\		20.11	ナh /ltom 23c) /5:== 5::		7427		July 10,				
de	W 14		30. Name and address of person who completed cause of dea ANWAR MUSH MS Suff 31. Date filed (Month, Day, Year) 32. Registray	பா (item 23a) (lype, Pri 2 3 ு) \$ (HospR	d Prin	ce Frei	berick .	MD 200 T8			
	Stat		31. Date filed (Month, Day, Year) 32. Registrar	Signature	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2012 Physician/ Haldane Leon 02:50 A.M Bovce July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year)1920 219-09-4567 91 **Director** 1 **X** M 2 □ F November 30. Barbados Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No District of Columbia Washington 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ò items 23a Funeral 635 Edgewood Street, N.E.; Apt. 503 20017 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 X Widowed 4 □ Divorced Year or Dates nit. Page 1 and 2 should be filed within 72 hours artment of Health and Mental Hygiene. oortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) **7th grade** College (1-4 or 5+) Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Boyce Louise Ashby 19a. Informant's Name/Relationship (Type, Print)
(Church Pastor & Guardian)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bishop Alfred A. Owens, Jr. 610 Rhode Island Avenue, N.E.; Washington, D.C. 20002 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or other cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ju1y 10,20124 Donation 5 Other (Specify) Heritage Memorial Cemetery Waldorf, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 M01421 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 Illnknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes ပ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pending work? Notified to the state of the st 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifie D0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Altmins Ses E State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:30AM Medical a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death ounty of Death **Examiner** MONTGOMER SILVER 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Hours Min. 8 Director ENDIA 28a-f shov with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director SILVER 1 🗆 Yes 2 No ems 23a or ? r must be n Funeral 20904 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural" Completed 3 Widowed 4 Divorced ASTAN 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working ntary/Secondary (0-12) al Hygiene. life. DO NOT use retired College (1-4 or 5+) the Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BDUL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2024 SHAUKAT Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 0/38 LANHAM MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death PNEUMONI Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-transit TNTRA ABDOMINA Physician/Medical MEDIASTINA the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🕶 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No has this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and hitle 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOREST GLEN RD STLVER SPRING, MD 20910 1500 32. Registrar's Signature anka Registrar

12-04990

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 23547 Aniyah Stephany Batchelor State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month D July 3, 2012 Medical Examiner 1351 hrs Aniyah Stephany Batchelor

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days Director Country) 1 M 2 X F Yre 218-87-2040 2 05/03/2010 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No show Maryland Prince Georges Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. anti- If item 27 is marked other than "natural", or items 23a or 28a-f sho ar other traumatic event, the Medical Examiner must be notified as non-Landover Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 805 Brightseat Rd. 20785 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Yaa 1 Yes 2 No specify: Specify: Black ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Not Applicable 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Antonio Batchelor Stephany Cunningham Be 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Social Worker) Keesha Tyler 805 Brightseat Rd. Landover, MD 20785 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 07/16/2012 Resurrection Cemetery Clinton, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Juneral Service License 9013 Annapolis Rd. Lanham, MD 20706 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a Blunt Force Torso Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed physician and the burial - transi Physician/Medical UNPENDED **AMENDED** Box 68760, IF FEMALE: 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o Þ 1 Yes 2 ✓ No 3 Probably 4 Unknown ₽. pleted Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be of Vital examiner? Other Nursing Home 5 Residence 6 Other DOA this 1 Yes 28a. Date of Injury (Month, Day, Year) Jul 3, 2012 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject was beaten 1 Natural 1208 hrs Division 5 Pending 1 Yes 2 ✔ No death. the Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Fuoeral Dire 3 Suicide Could not be or Town, State) 1815 Taylor Avenue, Fort Washington, MD determined (Specify) Single Family Home 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 4, 2012 Name and address of person who completed cause of death (Item 23a) OO Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>012</u> Physician/ \mathbf{A}^M 2:05 JUNE ANN B. BOSSERT Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** TALBOT EASTON WILLIAM HILL MANOR 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) Country) MARYLAND Funeral Months Days Hours (Month, Day, Year) 8/12/1915 1 □ M 2 🔀 F 96 Director 217-26-1715 Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No EASTON MD TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA **#118 LONDONDERRY** 21601 700 PORT STREET. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNA HOOPER 2 JAMES ELLSWORTH BUCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SARAH B. MCDAVID, DAUGHTER 7047 PINE RIDGE ROAD, EASTON, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION | 6/26/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET, EASTON, MD HOME, P.A. 21601 JUHN R MERCER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician BUAUCED disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate physician and s the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death g 🗌 Unknown g 🔲 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, EMPHYSELYA 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 XNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatura

10

State Registrar

7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 22/4PM 2 June JOHN LEWIS BOETTNER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital at Talbot Easton Memorial EASTON 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 236-66-2044 69 Director 1 M 2 □ F MARYLAND 06/18/1943 10c. City, Town or Location 10d. Inside City Limits 10b. Count ms 23e or 28a-f sho must be notified at 10a, State death with the Maryland Director 1 🗌 Yes 2 💢 No SAINT MICHAELS TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21663 24380 OAKWOOD PARK RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? 11 Marital Status ?7 is marked other then "natural", or iter traumatic event, the Medical Examiner 1 Yes 2 No John Boen 1 Never Married 2 X Married Pege 1 and 2 should be filed within 72 hours after ument of Health and Mental Hyglene. ent: If item 27 is marked other then "natural", or Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) RETAIL BUSINESS OWNER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ GRACE MITTER JOHN LEWIS BOETTNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24380 OAKWOOD PARK RD. ST. MICHAELS, MD 21663 LYNDA F. BOETTNER/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPERAKE) N Date ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State STEVENSVILLE, MD 06/30/2012 4 Donation 5 Other (Specify) CENTER 学生性受物等。 200 S. HARRISON ST. EASTON, MD 21601 21. Signatury of Fundral Service aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disease, or complications Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 250012,4 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Day 5 Other (specify) Pregnant at time of death Unknown th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate I 1 Yes 2 No 1 Yes 2 2N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 IDOA Certificate: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 12 TLS (Month, Day, Year)
JUL 0 2 2012 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 832 PM Day July 2012^{eai} Physician/ onal d Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner Montgomery Damascus 9025 Gue Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 217-28-7902 82 1 🖾 M 2 🗆 F Director July 1, 1930 Maryland Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Yes 2X No Damascus Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe 0 ms 23a or must be Funeral U.S.A. 9025 Gue Road 20872 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: res, Give Year or Dates,1951-53 Specify: White Completed 3 XWidowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Research Specialist U.S. Government 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Irene Tregoning Lester Barber Clara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellis R. Barber - Son 6920 Holter Road, Middletown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State Clustered Spires Cem. 7/9/2012 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Janeral Service Licer Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Veri 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Plu_ician/ 10 6-66 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner rononu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed 205 and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mell. his 2 ☐ No 3 ☐ Probably 40 ☐ Unknown Insut 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? performe after death.

Director: After this certificate I d in by the funeral director, pag CUA 1 Yes 2 No Yes 2 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident
3 Suicide injury 5 Pending 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Homicide City or Town, State, within 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pgactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person

T.

Gail

31. Date filed (Month, Day

DHMH 17 Rev 06-2011

1502 South Main Street, Mount Airy, Maryland

tho completed cause of death (Item 23a) (Type, Print)

RECEA

gistrar's Signature

Griffin, M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-05095 State of Maryland / Department of Health and Mental Hygiene Milton Lloyd Bradshaw Certificate of Death 1. For State Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day July 7, 2012 Physician/ 0903 hrs **Medical Examiner** Milton Lloyd Bradshaw 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dorchester Church Creek 3503 Golden Hill Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Foreign Months Days Hours Country) MD 06/09/1939 Director 73 Yrs 214-36-7222 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No 23a or 28a-f show Church Creek Dorchester MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21622 3503 Golden Hill Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12 Was Decedent Ever in U.S. 11. Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 X Yes Specify: White mit. Pages I and 2 should be filed within 72 hours after of partment of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", on ury or other traumatic event, the Medical Examiner m If Yes, Give Year 1962-19671 Yes $2 \times$ No specify: Divorced 3 Widowed ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Textile College (1-4 or 5+) Flementary/Secondary (0-12) MD 21215-0036 Manufacturing Maintenance Worker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lottie Elosie Elzey William Byron Bradshaw Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 3503 Golden Hill Rd. Church Creek, MD21622 Nancy K. Bradshaw/wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Church Creek, 7/11/12 Johns Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 308 High St. Newcomb&Collins FH Cambridge. -01 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death /Medical a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transit requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the Month Fetal death 3 Ectopic pregnancy 1 Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown <u>გ</u> Completed 24a. Was an 24b. Were autopsy findings available has been s e 2 should t prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 Yes certificate funeral director, page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death FOUND: Day, Year) Subject shot self Certification FOUND: 1 Natural 1 Yes 2 ✓ No c Funeral Director: A etely filled in by the fu 5 Pending 0830 hrs Jul 7, 2012 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 3503 Golden Hill Road, Church Creek, MD determined (Specify) Shed Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

NX/

DHMH 17 Rev 1/2001 OCME 2006

State Registrar O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

July 8, 2012

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio M.D., Ph. D.

D 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death =34pm Month Year Physician/ 0 ann Medical County of Death or Location of Death 4a. Facility Name (if not institution, give stre 4b. City, Town Examiner 4nne Trun Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days (Month, Day, Year) Hours Months 75 216-34-0160 **Director** 1 M 2 X F 6/3/1937 MD Usual Residence of Dec or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland is 23a or zou. must be notified a' **Funeral Director** 1 Yes 2 X No MD Calvert St. Leonard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA must 5751 Eucalyptus Dr. 20685 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. þ 1 ▼ Yes 2 No If Yes, Give Year or Dates. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: Specify 3 Widowed 4 X Divorced Completed th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Comptroller Naval Air Facility 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret E. Somervell John S. Latimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u> Monica Kilsheimer/ Da</u>ughter 2648 Greenbriar Ln., Annapolis, MD 21401 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 7/3/2012 Edgewater, MD 4 Donation Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Jun 2973 Solomons Island Rd., Edgewater, MD 21037 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1 Enter the disease, or shock, or heart failure. List of Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed? Yes 2 X No 1 ☐ Yes 2 X No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes I X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer. (Month, Day, Year) Natural injury 5 Pending 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

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Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

Name and address of person who completed cause of death (Item 23a) (Type, Print

06 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Physician/ 254 AM Beavers 2012 ean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citu Johns HOPKINS Hospita Bultimore 8. Date of Bir If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Months Director 579-34-2091 1 □ M 2 🙀 F 84 Yrs MD 9/13/1927 Usual Residence of Decede 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits be notified at **Funeral Director** 1 Yes 2 X No MD Edgewater Anne Arundel 10e. Street and Numbe 10f. Zip Code 0 10g. Citizen of What Country? 23a **Examiner must** 21037 USA 3709 Bay Dr. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ğ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee, Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virginia Sheetz Perry Price Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3709 Bay Dr., Edgewater, MD 21037 Richard C. Beavers / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/6/2012 Crownsville, MD MD Veterans Cem. 4 Donation 5 D 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat re 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ¾ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 A Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death n 24 hours after ucca.... he Funeral Director: After th inletely filled in by the funera Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 2 Accider 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 [only one 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1800 Orleans St Baltimore mo

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 2012 A M9 7:47 JOHN WILLIAM BECK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S QUEEN ANNE'S EMERGENCY CENTER OUEENSTOWN 9. Birthplace (State or Foreign If Unde If Unde 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours 578-48-5759 Director 1 🗶 M 2 🗆 F 78 Yrs 12/24/1933 ILLINOIS 10d, Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2 X No CHESTER MD QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 23a Completed by Funeral UNITED STATES 1703 SEWARD COURT 21619 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No 1956- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 1958 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MACHINERY SUPERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ JESSIE OPAL DAILEY JOHN M. BECK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1703 SEWARD COURT, CHESTER, MD 21619 JEANNE BECK / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date WOODLAWN MEMORIAL
PARK 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/12/2012 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MD 21619 21. Signal, e Licensee HOME, P.A. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that ca ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lor as a Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the s 9 Unknown Unknown been signed by t should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 24 hours after death.

Funeral Director, After this certificate 26. Place of Death (Check only one) 25. Was case referred to medica examiner? Hospital Other: ျ 1 🗌 Yes 2 🗗 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 only one 29b. Signature and title of certi

SHI

30. Name and address of person who completed cause of death

31. Date filed (Month Day,

GUM MD

Registrar
DHMH 17 Rev 06-2011

State

D0028686

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u></u>	11. Marital Status1 Never Marries3 Widowed 4		Armed For	rces? 2 🔼 No e		Yes, specify		Mexican, Pu Specify:	(Specify Yes or lerto Rican, etc.)			ck, White			
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68760	ertificate ding phy se as the	/Med	IF FEMALE:		23c. If yes, ou	tcome of pregna	ancy						23d D	ate of de	livery		
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed		-								Was an autops perforn Yes 2		prior to death?		ngs available of cause of	
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ivision	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determine	ot be 28e. Place	e of Injury - At ho ling, etc. (Specif		M reet, factory,		/es 2 □ N	28f. Locat	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ 1:48 P M 2012 Carrick JulyMedical Lester Jerome 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boonsboro Washington 62 Hillcrest Road Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number If Under 1 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months **Director** 579-24-6838 1 X M 2 🗆 F 1925 Maryland Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 뉽 10a. State Director Examiner must be notified 1 Yes 2 X No Boonsboro Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number , or items 23a Funeral U.S.A 62 Hillcrest Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. 1943-Specify: 3 Widowed 4 Divorced White "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Secondary (0-12) Government 11 Steamfitter marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Helen Hall Carrick Milton . Page 1 and 2 should ment of Health and M tant: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hillcrest Road, Boonsboro, Maryland 21713 <u>Betty J. Carrick/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If it any injury or o X Burial 2 Cremation 3 Removal from State 07/12/2012 Frederick, Maryland Mount Olivet Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. of Funeral Service Licensee Si tur Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Phy⊪i ian 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Litter Unidentitying Cause (Disease or injury Due to (or as a consequence of) Exami as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the ail g Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 No Division of Vital Records, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 N 1 Tes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: work? injury 1 Natural 5 Pendina 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Marse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signatu d title of cer Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

12

32.

Medistrar's Signature

Registrar

TOD: 0454 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ July 5 1330 Cleveland, Sr. М В. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours Months 577-34-7121 84 **Director** 1 X M 2 □ F 01/03/1928 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Middletown MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21769 United States 112 Rhoderick Circle 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 XYes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married \$ Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates. 1945–46 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Model Builder Engineering e 1 and 2 should be filed within of Health and Mental Hygiens of Health and T is marked other the rother traumatic event, the æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Irene Pea James Cleveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 112 Rhoderick Circle, Middletown, MD 21769 Janet Cleveland / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 7/9/12 Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License aquelle (lee 1621 Opossumtown Pike, Frederick, MD 21702 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Mary to Medical Examiner erebrovascular Accident week Sequentially list conditions, if any, coon good immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Dementia Many Years Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 the attending phone IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death n signed by the a 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Nother Springe house examiner? 2 No Hospital Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at Certificate: 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month. Dav. Year) 0

Registrar
DHMH 17 Rev 06-2011

State

Physician.

S. Main St.

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thaker,

1-10070147

Ste. 202.

Mt. Airy.

6

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 4. 2012 11:45 a^M SARAH RUTH COOLING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Alfred House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Director 212-18-2018
Usual Residence of Decede 1 🗆 M 2 🗴 F 97 June 6 1915 Virginia r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State the Maryland Director 1 Yes 2 X No MD Rockville Montgomery 123a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with. must 15417 Manor Village Lane 20853 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 9 ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the County Public School n Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Charles McCracken Daisy Bradshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other tran Peggy Cleaveland/Daughter 20853 15417 Manor Village Lane, Rockville, MD 20a. Method of Disposition 20h Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/12 Rockville, Maryland Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Barber Funeral Home 20 P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertension 20 +years disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Por Year Month Pregnant at time of death been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Dementia Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed? death? 2 🗌 No certificate 1 ☐ Yes 2 🗹 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 of Other (Specify) group home 1 Tyes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28a. Date of injury (Month, Day, Year) in 24 hours after deau...
in 24 hours after deau...
in Euneral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? iniury 5 Pending 1 X Natural Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou To the Fune completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) D 35336 July 5, 2012 hleena f. Shapur

9

State Registrar 10810 Connecticut Ave., Kensington, MD

20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Deena J. Shapiro, M.D.

31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Mary L. Cole July 5:30 p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 11 Davis Drive Indian Head If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) 1 🗆 M 2 🔀 F Director 577-40-7437 80 29. 1932 Washington D.C Jan. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral U.S.A. 11 Davis Drive 20640 within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager Real Estate Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Jennings Gaylor Helen Mae Robertson Page 1 and 2 should be ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Robin L. Young Daughter 20502 Aquasco Road, Aquasco, Md. 20608 Baltimore, 20a. Method of Disposition

1 Delian 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 12, Date 2012 20c. Location - City or Town, State Cheltenham, Maryland Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Signature of Funeral Serv 20640 lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the di shock, or heart fail Immediate Cause (Final Physician/ MORNS C disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine rt any, leading to immediate cause. Enter Underlying Cause (Disease or injury Lue lo loi as a consequênce on that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending ☐¹Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

a.

03

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2012 Month July Physician/ 21:09 Leroy Cromartie Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number Sex 7. Age (In yrs. last birthday, 8. Date of Birth Funeral (Month, Day Days Min. Year 1 🔀 M 2 🗆 F Yrs North Carolina March Director 241-32-2098 80 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State Director 1

Yes 2 □ No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 20019 United States 5334 Clay Terrace NE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Laborer 6th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Carrie Bell unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20019$ 19a. Informant's Name/Relationship (Type, Print) 2727 Fairlawn Avenue SE Apt. 305 Washington, DC Leroy Brown - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 12, 1 X Burial 2 Cremation 3 Removal from State Landover, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 21. Signature of Euneral Service License Stewart Funeral Home, Inc. 22. Name and Address of Facility 20019 Washington, DC Road NE <u> M00560</u> 4001 Benning 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Anterioscionore Candiovascular Onset and Death Immediate Cause (Final Physician/ ears disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a consequence of): Examine To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 2 No Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by emen's 1 Yes 2 No 3 Probably 4 Unknown Anoxic Enceptalorathy 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? ventilator Dependent 1 ☐ Yes 2 ☐ No Lesaination 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 1 Yes 2 No ၉ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Devone 42

State Registrar 32. Regirtrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06/28/2012 2:05 WILLIAM EMMETT CRANE II Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **EASTON** TALBOT WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs 6. Sex 1 **X** M 2 \square F 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 12/20/1923 NEW YORK Director 061-18-4905 88 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f shr must be notified a1 Yes 2X No MD TALBOT ROYAL OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4780 FERRY NECK RD. 21662 USA ıral", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: WHITE 3 Divorced 4 Divorced Year or Dates. er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) VICE PRESIDENT OF SALES CONSUMER GOODS 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ZENA EMILINA PURCELL HENRY DEVOE CRANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4780 FERRY NECK RD. ROYAL OAK, MD 21662 CHERRON C. CRANE / WIFE item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o of 1 Burial 2 Cremation 3 Removal from State 07/02/2012 SPRINGHILL CEMETERY EASTON, MD 4 Donation 5 D Other (Specify) PENSHOWS GOTHER FENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of Exami The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page perform death?
1 Yes 2 No Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital Other: 2 No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury s after death.

I Director: Af
d in by the fur 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

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State Registrar

31. Date filed (Month, Day, Year) JUN 2 9 2012

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0	Examin	·.	4a. Facility Name (if not institution, give stre Genesis HealthCa	are-The		Easto			4c. County Talb	
	Funeral Director		3//-10-0020	7. Age (fi	n yrs. last birthday) 81 Yrs.	Months Days	If Under 24 Hrs Hours Min.			9. Birthplace (State or Foreign Country) MARYLAND
	show d at	ō	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Loc	ation	-			10d. Inside City Limits
	Maryli 28a-f	Director	MD TALBOT		EASTON			·		1 ☐ Yes 2 ሺ No
	within 72 hours after death with the Maryland giene. ethen "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral D	10e. Street and Number 11340 LONGWOODS RO	AD		10f. Zip Code 21601			10g. Citizen of V USA	Vhat Country?
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Virginia Callahan Baltimore, Maryland 21215-0036	be filed ental Hy ked oth c even	To Be	17. Father's Name (First, Middle, Last) THOMAS EDWARD WALLS	3				me (First, Middle, WATTS	, Maiden Surname)
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/irg more	0		20a. Method of Disposition 1	moval from State	20b. Place of Dispo cemetery, cren WOODLAWN	atory or other pla-		Date 8/2012		City or Town, State MARYLAND
Balti	permit. Page Department of Important: In any injury or		21. Signature of Funeral Service Licensee	ERCER		Name and Addre LLOWS, F	ÎÊLFÊNBEI HARRISON	N & NEW	NAM FUNE	RAL HOME, P.A., MD 21601
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Division of Vital Records,	nding Phy ath. : After this e funeral d	cate: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Y	2 ER/Outpatien 28b. Time of injury	28c. Injur worl	ry at		idence 6 Othe	
Divisio	al or Atter s after des Il Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, stre Specify)	et, factory, office		28f. Location (City or Tox		er or Rural Route Number,
-	the Hospits thin 24 hours the Funera mpleted fille	Medical	29a. Certifier (Check only one)	: On the basis of exar	nination and/or invest	gation, in my opini	on, death occurred	at the time, date	and place, and due	e to the cause(s) and manner stated.
	CAT.		29b. Signature and title of certifier Michaele	Verna	CRNP	29c, Licens	7319	3	29d. Date signed	1 (Month, Day, Year)
lo			30. Name and address of person who com	pleted cause of deat			Eas	non, CR	MI	21/21
7	Stat		31. Date filed (Month, DH Nr) 2	32 Registar's	Signature 4	X /	<u> </u>	1011	ייש	2101

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 3, Physician/ 2012 9:35A Palma W. Deem Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Fort Washington 2600 Rose Valley Court Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min 361-05-0323 1 □ M 2 🏋 F **Director** 100 1/12/1912 Kentucky Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No Maryland Prince George's Fort Washington Citizen of What Country? 10e. Street and Number 0 d Mental Hygiene. marked other than "natural", or items 23a or matic event, <u>the Medical Examiner must be r</u> 20744 Funeral 2600 Rose Valley Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black White etc þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Clerical Federal Government Be 17. Father's Name (First, Middle, Last) Page 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) ပ Phinia Belle Patton Bluford Edward Whitehouse other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2600 Rose Valley Court, Ft. Washington, MD 20744 Shirley D. Gillespie/Daughter f Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
Important: If ite
any injury or otl
once, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7/7/2012 Brentwood, MD 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 21. Signatur f Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, MD 20745 ales 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Arteriosclerotic Cardiovascular Disease Physician/ Years disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Hospital or Attending Physician: The law requires that the death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the all Id be detached f 1 Yes 2 D g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 2 No Aortic Stenosis 1 Yes been signatures 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has autopsy performed? Yes 2 No 1 Yes 2 No After this certificate 25. Was onse referred to medical examiner?

1 N Yes 2 No funeral director, 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director; A

completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 06 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael E. Leibowitz, M.D. 11120 New Hampshire Ave. Suite 305, Silver Spring, MD

D08089

July 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State State Registrar	e of Maryland	•	tificate of D		vientai my	Reg. No. 2	112	23566			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De	in Day	Year	3. Time of Death			
**	Medic Examin	_	Patricia Ann 4a. Facility Name (if not institution, give street and	Frey		4b. City, Town, or	Location of Death		4c. County	111.70				
)	LAGITIII		Meritus Medical Cen	ter		Н	agerstow	n.		Washi	ington			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthp Count	lace (State or Foreign ry)			
	Director		464-90-8800 1 ☐ M 2 ☐ Usual Residence of Decedent	KF 61	Yrs.			March	24, 1951	Mar	yland			
	and show	ō	10a. State 10b. County	10c. City,	Town or Loc	cation					0d. Inside City Limits			
	Maryl 28a-f otifiec	Director	Maryland Washington	Вос	onsbor						1 🗌 Yes 2 🛣 No			
	th the 3a or t be n	al D	10e. Street and Number			10f, Zip Code			10g. Citizen of					
	ath wi	Funeral	6926 Mariah Furnace 11. Marital Status 12. Was	Road Decedent Ever in U.S.	13. V	Vas Decedent of His	21713 spanic Origin? (Sp	secify Yes or No-	14. Rac	U.S.A				
9	er dez or ite miner	by Fi	1 Never Married 2 Married 1	d Forces? Yes 2 👿 No	1	Vas Decedent of His Yes, specify Cubar		o Rican, etc.)		ck, White, e	etc.			
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at the Medical Examiner		3 X Widowed 4 □ Divorced If Yes	or Dates.		Yes 2 X No			Specify	W	nite			
15-(72 hoi "nat	Completed	15. Decedent's Education (Specify only highest grade comp	eted)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		king	16b. Kind of B	usiness/Inc	dustry			
212	ed within Hygiene. other thai	ပြီ	Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)	me. D	Homema	ker		Ov	n Hor	ne			
pu	교육독世		17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle	, Maiden Surnam	e)				
yla	should be file n and Mental H 7 is marked o raumatic eve	욘	Alle <u>n Mullan</u>				JoAnn	Mcmi						
Maryland	2 should be th and Men 27 is marke traumatic	- 1	19a. Informant's Name/Relationship (Type, Print)	/m		ng Address (Street a								
	nd leal m	1	Melissa A. Richardso	20b. Pla	ce of Dispo	sition (Name of		<u>l, Falr</u> Date	20c. Location					
ШO	Page 1 a nent of H ant: If ite ary or otl	1 (1 ☐ Burial 2 X Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	IIOIII State		cremator	i	13/2012	Freder	ick.	Maryland			
Baltimore,	permit. Page Department of Important: If any injury or once,		21 Signature of Funeral Service License	her	22	. Name and Addres	s of Facility Ba	st-Stau	ffer Fur	neral	Home, P.A. land 21713			
Е			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause							T	Approximate Interval Between			
	hysicism/		Immediate Cause (Final disease or condition	rearis							Onset and Death			
J	Medical Examiner	П	resulting in death) Due to (o, vas a consequence of):											
01		je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
	exectian an	EX	resulting in death) Last Di	ue to (or as a conseque	nce of):									
200	sate be executed physician and s the burial-transit	edical	d											
687	hat the death certific ed by the attending I detached for use as	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	s, outcome of pregnanc	су				23d. Da	ate of delive	ery			
Вох	e atter	Physician/M	in the past 12 months?	Live Birth 2 Fetal of Pregnant at time of de Unknown		Description of Ectopic pregnance of Other (specify)	У				Day Year			
P.O. E	t the c by the	Phys	9 ☐ Unknown Part II. Other significant conditions contribution		ting in thou	inderlying cause giv	en in Part I	age Did	tobacca uso con	tributa to th	ne cause of death?			
ds, P.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transi	Completed by	Sialities, CKD, ch								pably 4 🗆 Unknown			
of Vital Records,	has bee	plet						24a. Was auto	psy	prior to co	osy findings available mpletion of cause of			
Re	The la cate ha							1 🗌 Yes	ormed? 2 No	death?	2 🗆 No			
ital	ysician: The is certificate director, pag	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ E	D/O 4	I Out	ace of Death (Che		:	· · · (Cassifi	a .			
of V	ding Phy: h. After this funeral d	e: To	27. Manner of Death 28a.		8b. Time of injury		/ at	1	idence 6 🗌 Oth how injury occur)			
	Attending or death. sector: After by the fune	ficat	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	Yes 2 No							
Division	al or Att s after de il Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or To	(Street and Numb wn, State)	er or Rural	Route Number,			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: v completely filled in by the	Medical	29a. Certifier (Check conly one) 3 Certifying Physician: To 2 Medical Examiner: On to 3 Certifying Nurse Practi	ne basis of examination :	and/or inves	tigation, in my opinio	on, death occurred	at the time, date	and place, and du	ie to the cai	use(s) and manner stated.			
	To th within	-	29b. Signature and title of certifier	1		29c. License		/	29d. Date signe					
ナナ	W-4		30. Name and address of person who completes Robert Guedenet 21	cause of death (Item 2 Wyand Dri		Print)		58						
4	Sta Registr		31. Date filed (Month, Day, Year) 3 2012	00 Defintanta Cinneta		Sacket .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #25 per med cert G930 8///12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $J_{\mathbf{uly}}^{\mathsf{Month}}$ Sarah Viola FARRIS 2012 2222 PM 9 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 607 Guilford Avenue Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Sept.6, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Min. 1 🗆 M 2 🔀 Hours ^{Yea}r) 1934 216-30-3191 77 Director Maryland Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified 28a-f Maryland Washington Hagerstown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 607 Guilford Avenue 21740 USA ural", or items ? I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married "natural", or Completed by ☐ Yes 2 🛛 No Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker her own home and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Eakle Alvey Mowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) upportment of Health an Important. If item 27 is any injury or any Brenda Rhinaman - daughter 933 Frederick Street, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 7/13/12 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of oneral Service License MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ancer months disease or condition resulting in death) Mknown Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Live Birth
4 Pregnant for (Day Pregnant at time of death n signed by the a ld be detached for 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Onknown 1 Yes To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perfori Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Division Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print 31. Date filed (Month 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:00 AM June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westmin ster Carroll Hospice Dove 8. Date of Birth (Month, Day,) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Hours ZIZ 26585 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo!" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location Funeral Director 1 🗆 Yes 2 😿 No vin 10g. Citizen of What Country 10e. Street and Numbe 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) phone 10 Be 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Schuessl UNKHOWN daughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Zip Code) 45 Filber Ritterman 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City 1 Natural 2 ☐ Cremation 3 Nature Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jefferson (21. Signature Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) completed filled in by the funeral director, Hospital Certificate: To 1 \square Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Tyes Accident Investigation within 24 hours after deatl To the Funeral Director, Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Name and address of pe Year Registrar's Signature State 0 Registrar

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Division of Vital Records, P.O. Box 68760	

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			For State Registrar		State	JI IVIAI YI		tificate			ariu iv	nemai i iy	Reg. N	20	112	2356		
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	Funeral		5. Social Security N 213-44-5	lumber	6. Sex	7. Age (In yı	s. last birthday)	If Under Months		If Under Hours		8. Date of Bi	rth			lace (State or Foreign		
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Maryland	uld be I Ment narke natic	2		Frederick McLaughlin						_		thy She						
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	j	19a. Informant's N Joseph									1 Road,				ode) 20882 g, MD		
Baltimore,					3 ☐ Removal from	State	b. Place of Dispo cemetery, crer ate of H		ther place	е)		Date y 11, 12		Location -	-	wn, State		
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	Medical Examiner			art failure. List o (Final on	complications that only one cause on e											Approximate Interval Between Onset and Deat		
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. Box 68760	certifi inding use a	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months? No		Birth 2 🗌 i gnant at time	etal death 3	Ectopic p		у				23d. Dat	e of deliver	ry Day Year		
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ital	Attending Physician: The sr death. ector: After this certificate by the funeral director, pag	Be	examiner?	Hospital: Other:														
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Division	al or Attend s after death al Director: A ed in by the f		4 Homicide	determ	inad 28e. Place	e of Injury - Ai ing, etc. (Spe	t home, farm, str cify)	eet, factory	, office			28f. Location (City or To			er or Rural F	Route Number,		
_	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	Medical	(Check :	2 Medical E	Physician: To the backaminer: On the ba	sis of examina	ation and/or inves	tigation, in r	my opinio	n, death o	ccurred at	the time, date	and plac	ce, and due	to the caus	se(s) and manner stated.		
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97 VK	Sta Registr		31. Date filed (Mon	th, Day, Year) L 102	012 Sen	Registrar's Sig	sture face	4										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year July Physician/ 3:35 Рм 6 Aileen Fowler Mamie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 3015 Woodlow Drive Huntingtown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 217-36-8986 **Director** 1 □ M 2 🗓 F 90 07-05-1922 Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 X No Huntingtown MDCalvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20639 3015 Woodlow Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Clothing Boutique Sales Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russel Myrt1e John Woodley Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Woodlow Dr., Huntingtown, MD Sophia L. Brown, granddaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-9-2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. illiam R. Giv 8325 Mt. Harmony Lane, Owings, MD MO0715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line interval Between Onset and Death Immediate Cause (Final KIDNEY Physician/ UNIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant a Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed rellit's I Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? (Quinoma 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2-No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1-Natural iniury 5 Pending 24 hours after death Funeral Director: A Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hours to the completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 110 Hospital Rd., Ste. 305, Pr. Fred., MD 20678 10 Mukesh Mathur, M.D., 31. Date filed (Month, Day, Year) 32. Registrar Signature State

Registrar

JUL - 9 7012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:45 A M Marie Fowler June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner B<u>ethesda</u> Montgomery ManorCare 6 Sex 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. (Month, Day, Year) Director 579-84-1970 1 M 2 X F 85 11-10-1926 PA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MdBethesda Montgomery 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 6530 Democracy Blvd 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hazel Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Eastern Ave., NE Washington, DC Star Fowler / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 7/5/12 4 Donation 5 Other (Specify) Brentwood, Md Signature of Funeral Sen ice Licensee. 22. Name and Address of FacilityFort Lincoln Funeral Home Weta Marcis 3401 Bladensburg Rd Brentwood, Md. 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) 1 Yes 2 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform 1 Yes 2 No 1 ☐ Yes 2 🕏 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🖁 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accider iniury 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Gens, MD 00057129 2 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive Suite #206 Rockville, Md Truong Bao, MD Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-State PartII, TCHD, 6/28/2012Certificate of Death TLS Amended 23 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06/mth Mary Matilda 22 2012 7:43P M Tripline Farmer Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Talbot 300 Brooks Lane St. Michaels Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Hours 1 M 2 X F 0170571916 96 MD. 577-38-1783 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD. Talbot St. Michaels 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 300 Brooks Lane 21663 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 XNo Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home -0-Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be find Health and Mental fitem 27 is marked 0 Cornelia Bailey Franklin Clarke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John W. Tripline, 1200S. Washington St. Easton, MD. 21601 SR./ son or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 6/30/2012 St. Michaels, MD. Thomas Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hurley Ades Ostirowski Funeral Home P.A. Woseph M. Ostesnor ki 518 St P.O. Box Michaels. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final NVASIVE Physician/ MONTH disease or condition resulting in death) Medical (or as a consequence of): Examiner JEMIA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the 1 ☐ Yes 2 2 Unknown Division of Vital Records, P.O. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an VASCULAR performe To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) License number 29d Date signed (Month, Day, Year) 29b. Signatu TLS of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2217 M Fiddermon 2017 silliam Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Maryland Medical (timore If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Director 1 D M 2 D F nia or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at with the Maryland Director 1 Yes 2 No ambrid 10g. Citizen of What Country? 10e. Street and Number Funeral hateau 61 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Xes 2 No 1974 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Yes Give Black Completed 3 Widowed 4 Divorced Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) employed iver injury or other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental P. Important: If item 27 is many injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 -iddermon ee 00 er 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316C Road Can eau dderMon 20c. Location City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 3 salem, 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Acility HOME Henry washington St. Cambri Funeral eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ hemorrhad cilvedar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner week Johnson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy perform death? 1 ☐ Yes 2 🗷 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending 1 X Natural 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 60914 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 829 Schuchman N

State Registrar 31. Date filed (Month, Day, Year

Registrar's Signat

Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month July АМ 2012 3:54 William Foster Alfred Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Chesapeake Woods Center 525 Glenburn Avenue Cambridge If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) 1 🛛 M 2 🗆 F Maryland Director 216-18-8951 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at 10a. State 10b. County Director 1 X Yes 2 No 28a-f Cambridge Maryland Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö . Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

Fant: If item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examiner must be I Funeral 21613 United States 2305 Church Creek Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Year or Dates. 1943-1946 **Black** Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Textile Weaver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Naomi E. Opher William K. Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trappe, Maryland 21673 29926 Piney Hill Road Deborah E. F. Wooden / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State July 14, 2012 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Christ Rock Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 812 Hubbard Street Robert Boardle Cambridge, Maryland 21613 Boardley Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 54exs disease or condition resulting in death) Congestive Medical Due to r as a consequence of Examiner neumonia Sequentially list conditions cause (Disease or linjury cardiovas cular desease 2th levos levotic the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital R. cords, P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months? for Yes 2 No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Completed by 2 No 3 Probably 4 Unknown obstructive cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 🗌 Yes 2 🗌 No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical director examiner? Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred After t Certificate: (Month, Day, Year) injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation 6 Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

jex b

101 31. Date filed (Month, Day, Year) State Registrar

ricia

Johnson Registrar's Signature

Bramble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Eleanor Godlove 2012 Julv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16833 Tammany Manor Rd. Washington County Williamsport 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Days Months Hours 235-30-5685 Director 1 □ M 2 🂢 F 87 West Virginia Sep. 8,1924 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at Director 1 Yes 2 X No Maryland Washington County Williamsport 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō items 23a Funeral 21795 U.S.A. 16833 Tammany Manor Rd. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc. 10 1 Never Married 2 Married 2 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White "natural", Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Hospital Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Girod Anthony Colarusso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other tran Martha Godlove Ridenour-daughter 16833 Tammany Manor Rd. Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 7-17-2012 Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licens 1331 Eastern Blvd. North Hagerstown, al Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1. Enter the disease Immediate Cause (Final Physician/ Atheroselens disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: has autopsy performed certificate 1 Yes 2 No 1 Yes 2 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. Accident Investigation Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State Medical 29a. Certifier 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29c. License number 29b. Signate 2012 16 1)0056783 Jeffrey D. of death (Item 23a) (Type, Print) mill Surte 600 Hag erstown MD 21140 State

Registrar

AMEND #25, PER ME G93 at 10/ 3/12/land Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ladhil rista Medical 4a. Facility Name (if not institution, give street and number) . County of Death 4b. City, Town, or Location of Death **Examiner** Maryland Medical Cente Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-23-9295 1-15-1986 Director 1 □ M 2**X**] F 26 MD Usual Residence of Decedent show 10a. State MD 10c. City, Town or Location Hagerstown 10d. Inside City Limits must be notified at Director Washington 28a-f 1 X Yes 2 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 422 Summit Ave. Apt 21740 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 2000. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. 1X Never Married 2 ☐ Married Completed by white 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Salon 12th grade College (1-4 or 5+) Hair Stylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David A. Gladhill Holly A. Reed 19a. Informant's Name/Relationship (Type, Print) parents 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13412 Big Pool Rd. Clear Spring, MD 21722 Holly & David Gladhill 20a. Method of Disposition 20b. Place of Disposition (Name of -13^{Date}2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkhead" Cemetery Big Pool, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 23a. Part 1. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Subarachnoid Hemorrhage) Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examil burial-tran CERTIFICATION PPROVED BY Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death
Unknown Day the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has page 2 autopsy perforn hin 24 hours after death.

the Funeral Director: After this certificate Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) 힏 1 X Yes -2 X No Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certifier leu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State egistrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Physician/ Meredith Eugene Gross 7:40 a M $J_{u}^{\text{MOR}} 2$, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Carroll 4b. City, Town, or Location of Death Examiner Taneytown 103 York Street If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 217-28-6864 **Director** 1 M 2 🗆 F 79 Yrs Maryland Oct 4, 1932 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified Taneytown 1 Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 103 York Street **USA** and 2 should be filed within 72 hours after death wealth and Mental Hygiene.

tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. event, the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🗙 No Specify: Yes. Give 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Manufacturing Master Electrician 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suma. Elsie Grace Heffner မ Leslie Guy Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 York St, Taneytown, MD 21787 19a. Informant's Name/Relationship (Type, Print) Betty Jean Gross, wife 20b. Place of Disposition (Name of cemetery, crematory or other pland Evergreen Memorial 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/6/2012 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ATHEROSCLEROSIS Onset and Death Immediate Cause (Final Providin/ years disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion above. Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? after death.

Director: After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{K}\) Residence 6 \(\sum \) Other (Specify) 2 No မ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 0014317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONE KIPGS DRIVE TAPEYTOWN, MD 21787

State

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6, ^D2012 PAUL. GOODWIN July A^{M} 8:42 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7528 Epsilon Drive Derwood Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) Days Hours Min. **Director** 217-54-0486 1 **X**M 2 □ F 61 March 10, 1951 Massachusetts rral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🏋 No Maryland Montgomery Derwood 10e. Street and Number 10g Citizen of What Country? Funeral 7528 Epsilon Drive 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 X Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Divorced 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Senior Auditor 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Stanley Alton Goodwin Sara Elizabeth Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Goodwin/Spouse 7528 Epsilon Drive, Derwood, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 $m \stackrel{K}{
m M}$ Burial 2 $m \square$ Cremation 3 $m \square$ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery 07/10/2012 | Germantown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home MO1202 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Promisian/ ryocarlial disease or condition Medical resulting in death) Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Pregnant at time of death Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi

Completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in according to the state. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 212 29018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day,

Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ July 6, 5:05 P M Bernice Elizabeth GOLDBERG Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Montgomery Rockville Maple Ridge Assisted Living Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. **Director** 577-44-6222 1 □ M 2 💢 F 81 Oct. 23, 1930 Washington, DC Usual Residence of Dece ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? by Funeral United States 20906 15100 Interlachen Drive #1023 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, marked other than "natural", or ite matic event, the Medical Examiner Black, White, et white 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home 4 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F ည Harriet Ettinger Maurice H. Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 Interlachen Dr., #1023, Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) t: If item 27 is Howard O. Goldberg, Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Memorial Garden 07/09/12 permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Falls Church, VA Donation 5 Other (Specify) 21. Signature of Funeral Service Lio Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington. 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinced to the Funeral Director. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 🗌 No Yes 2 🗓 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Certificate: To Be Assisted Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specification) 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 🔲 Yes Living 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 \square Yes 27. Manner of Death 28d. Describe how injury occurred injury X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 0063195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20814 8600 Old Georgetown Road, Bethesda, MD

M.D. Steven Wilks, I. Date filed (Month, Day, Year

3 E

29b. Signature and title of certifier

29a. Certifier only one)

State Registrar 29d. Date signed (Month, Day, Year)

July 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ 5:25 a^{M} July CARROLL JOSEPH GIULIANI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brinklow 19911 New Hampshire Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days (Month, Day, Year) Months Hours 80 579-40-9658 **Director** 1 MM 2 □ F Yrs 27 1931 Washington, D.C. Sept. 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 ☐ Yes 2 🗹 No Brinklow MD Montgomery 10e. Street and Number 10f. Zip Code ō 10a. Citizen of What Country? 23a Funeral 20862 19911 New Hampshire Avenue United States "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black White, etc. Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Electrical Engineer Education of Health and Mental Hygi item 27 is marked othe other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rose Ccecarelli Carroll Giuliani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20862 19911 New Hampshire Avenue, Brinklow, MD Anne G. Myers/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ° <u>∓</u> ° cemetery, crematory or other place) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Department of Important: If any injury or 07/07/12 Metropolitan Crem. Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barber Funeral Home Barbe 04 Laytonsville, Maryland 20882 P.O. Box 5038 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Amyotrophic Lateral Sclerosis disease or condition resulting in death) 4 months Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Yea Pregnant at time of death n signed by the at g Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After work?
1 Yes 2 No 1 🗹 Natural injury 5 Pending ☐ Accident Investigation 24 hours after death Funeral Director; Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 🗆 ithin the F the only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title @ 0035045 July 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip G. Henjum, M.D. 18109 Prince 0 18109 Prince Philip Dr., #200, Olney, Maryland 20832 31. Date filed (Month Day, Y Year) 32. P. gistrar's Signature State 2012

DHMH 17 Rev 06-2011

Registrar

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Funeral		Security Number	6. Sex		7. Age (In yr:	s. last birthday)		der 1 Year	If Under 2	4Hrs.	8. Date of B			9. Birth	place (S	tate or
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Baltimore, MD 21215-0036 Painti. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Reath and Mental Hygiene. Important: If item 27 is marked other than "outural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be softlined at soccaling or other transmatic event, the Completed by Funeral Director	10e. Street	tand Number Hinton I)rive				10f. Z	ip Code 20639	9			10g. Citize	en of Wha J.S.A		ry?	
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	3 🗌 Su	de	ould not be etermined			t home, farm, st	eet, factor	ry, office bu	ilding, etc.	- 1	or Town,	State)				Number, City d, Huntingto
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drw 10		dore M. King, J				I Examiner	900 W	/. Baltimo	ore Street	t, Balt	timore, M	D 21223	3			
State Registrar		led (Month, Day, Yea	6 2012	32. R	gistrar's Sign	ature	a de	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ June 28, 2012 Sharon Denise Bailey Gardner 8:34 A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yeal 951 Months Days Hours 577-66-9644 Director 1 🗆 M 2 🗶 F 61 Washington, D.C. January 3, iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1602 Brightseat Road; Apt. 101 20785 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Maryland 21215-0036 72 hours after Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** Specify: "natural", 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Domestic 10th grade Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic Herman Ervin Bailey, Sr. Barbara Easther Staley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20032 19a. Informant's Name/Relationship (Type, Print) Earl Bernard Staley (Brother) 3630 Brothers Place, S.E.; Apt. 301; Washington, D.C. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 7,2012 Page 1 ment of Ξ 1 X Burial 2 Cremation 3 Removal from State permit, Page Department Important: It Suitland, Maryland Washington National Cemetery 4 Donation 5 Other (Specify) any injury 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Juneral Service M01421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each lim Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar and that initiated events resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month yes 2 No 5 Other (specify) Pregnant at time of death ned by the a e detached 1 a | Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be a Completed by 2 No Records, 3 Probably 4 Unknown 1 Yes been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perforr death?
1 Yes 2 No Yes 2 No this certificate the funeral director, **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? ျှ 1 🗌 Yes 2 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Yes 2 No 2 Accident 124 hours after death le Funeral Director: A oletely filled in by the Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date sign d (Month, Da s of person who completed cause of death (Item 23a) (Type, Print) a

Registrar

strar's Signature

12-05149

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

esmond Green		State of Maryland / Department of He 1-For State Certificate of De		lentạl Hyg			12 2358
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)		2	Reg. Date of Death		3. Time of Death
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E	4	1000 Galais Street		Under 24Hrs.	8. Date of Birth		Birthplace (State or
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	H	Usual Residence of Decedent			oury ry	2001	Country) Africa
ku k	Ī	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
nd show	ᆡ	Maryland Prince Georges Oxon Hill					1 Yes 2 No
hours after death with the Maryland 'natural', or items 23a or 28a-f show Examiner must be notified at once.	Director	10e. Street and Number 4609 Calais Street	Zip Code	20744	10g	. Citizen of What C United S	
th the 23a or Botific	_				7.VN-	Las Barras	verices Indian Block
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ter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No spe	ecify:		Specify:	Black
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5-0036 led within 72 hours al 1ygiene. other than "natural the Medical Examin	Completed	Twelfth None Construc			ing Middle 840	Priv	ate
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2121 uld be fil Mental J marked	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addi	ress (Street and	Number or Ru	ral Route Numbe	er, City or Town, S	tate, Zip Code 28328
MD d 2 sho lth and n 27 is	-	Andrew Allman/Cousin 32 Sawto	oth Oak	Circle	Bunnley	el, Nort	th Carolina
9 a a 5 E	Ī	20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition crematory or other place.		July		20c. Location - City	y or Town, State
MOI Pages ent of nt: If		Heritage Men	norial	2012		Waldorf.	Maryland
Baltimore, permit. Pages 1 at Department of Hee Important: If ite	t	21. Signature of Funeral Service Licensee Terry A Austin 22. Name	and Address of F	acility Rob			ral Home Inc
	<	1601	Good Ho	ope Rd :	SE Washi	ington do	20020
∠ Physician	ı	23a. Part Enter the disease, or complications that caused the death. Do not enter the mofailure. List only one cause on each line.	de of dying, such	as cardiac or r	espiratory arrest	r, snock, or neart	Approximate Interval Between Onset and Death
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Box 68760, e death certificate b the attending physical for use as the burner of the b	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown					
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cords, law requir has been s	be				autopsy perform	prior	to completion of cause of
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. Al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Othe	Prath (Check on		esidence 6 🗸 0	ther: Scene
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on Coding	틾	1 X Natural 5 Pending (Month, Day, Year)	1 Yes	2 No			
r Atte r Atte ter dez irecto n by tl	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	tory, office buildir	ng, etc. 2			Rural Route Number, City
Division of Vospital or Attending Ph hours after death. Superal Director: After ty filled in by the funeral	Certification:	4 Homicide determined (Specify)			or Town, Sta	te)	
e C = -		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	t the time, date ar	nd place, and d	ue to the cause(s) and manner as	stated.
To the Ho within 24 To the Fu completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.					
	₹	29b. Signature and title of certifier	29c. License nur O.C.M.E			29d. Date signed (July 10, 2012	wonth, Day, rear)
	ļ	UMBD	J.J.IVI.L				
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W.	Baltimore Str	reet, Baltimo	ore, MD 212	23	
St	ate						
Regist	rar	1111 1/E 9040 %					
DHMH 17 Rev 1/20 OCME 2006	01	ORIGINAL			OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ 2012 14 4:40 A M Shirley Ann Gist Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Senior Constant Care Assisted Living Sykesville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Min (Month, Day, Year) Hours **Director** 218-26-4856 1 □ M 2 X F 06/12/1930 MD Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Funeral Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n USA 21157 2150 Old Washington Road permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify. White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Thacker မ James E. Burns 19a. Informant's Name/Relationship (Type, Print)
Michael Gist/son 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code) 2150 Old Washington Road, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 07/18/2012 Westminster, MD Deer Park Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Pritts Funeral Home and Chapel, PA 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Velay > Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. der Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 m 5 Other (specify) Month Pregnant at time of death Day Year signed by the all Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes To the Funeral Director: After this certificate has been sis completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 7. Mannes of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier

Registrar

PROGRESS WAY

ELDERS BURG MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

380

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #25 per me, g930 8-3-12 sm

State of Maryland Department of Health and Mental Hygiene

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		_		Registrar 1. Decedent's Nam	ne (First, Middle,	Last)		Ce	runcate of L	Jeann_		2. Date of De	Reg. N	0.	11/	3. Time of	Death
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4	22.000	_i Examin		4a. Facility Name (ii	not institution, g	give street and num	ber)		4b. City, Town, or	Location o	of Death			c. County	of Death	1333	
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1	mo	Page 1 nent of ant: If i		1 X Burial 2 4 ☐ Donation	Cremation 3	B ☐ Removal from ec <i>ify</i>)	State	cemetery, crei	natory or other placed. Cemeter		July 20	y 5, 012			,	arylan	nd
0	Baltimore,	permit. Page 1: Department of H Important: If ite any injury or of		21. Signature of Fu	neral Service Lic	\mathcal{D}	MOO	22	2. Name and Addres	ss of Facility	y Eli	ine Fur	iera	1 Hor	ne		
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		Stat Registra		31. Date filed (Mont	h, Day, Year)		egistrar's Signa	ityle	Print) 2401 Dinci:	1		0					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 3. Time of Death Physician/ Phillip 930mm Hane 2012 10 Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death **Examiner** Boonsboro Fahrney washingtor Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 219-54-0921 **Director** 64 1 X M 2 □ F Feb. 1,1948 Pennsylvania Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland astronent of Health and Mental Hygiene. Astronent of Health and Mental Hygiene ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Boonsboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8507 Mapleville Rd. 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 X Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip C. Haney Elizabeth Laut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 145 Shady Grove, PA 17256 James Haney-brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 7-12-2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Parkinson's Disease vears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dementia lears Sequentially list conditions Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 🗌 Yes of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🗆 No Hospital: Other: 2 1 🗀 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' Division 1 Tyes 2 🗌 No 2 Accident Investigation within 24 hours after death To the Funeral Director: Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death one d at the time, date and plane, and due to th Yate m Smith CRNP R128088 7-10-2012 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW-15 1126 Opal Ct. Hagerstown, MD 21740 Kate MSMITh, 31. Date filed (Month, Day, Year) State Registrar

Phillip

Box 68760. or Attending Physician: The law requires that the death certificate be after death. P.0. Division of Vital Records,

Director: / Hospital

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

cal

5 Pending investigation

6 ☐ Could not be determined

- cuts on

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 WE MILLE IT DATTA VASANT 31. Date filed (Month,

28a. Date of Injury (Month, Day, Year)

and manner stated.

gistrar's Signature

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0 (8015

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

MACERSTOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) JULY 10, 2012

NO 21748

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month .35 PM SHIRLEY C. 11124 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Sanctuary at Holy Cross Burtonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Oct. 9, 1934 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Birtripic Country) DC 1 M 2 Set F 577-46-1232 77 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits within 72 hours after death with the Maryland Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 x No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14907 Claude Lane 20905 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2X Married 2 X No Completed by Yes Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ith and Mental Hyglene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 US Dept. of Justice Contract Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည H. Kent Conner Mildred Edmonds t. Page 1 and 2 should be thent of Health and Men rtant: If Item 27 is marke jury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael K. Haney / Husband 14907 Claude Lane, Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 2012 20c. Location - City or Town, State Department of Important: If It any injury or conce. cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final POSTRUCTION Physician/ BOWEL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if an leadin to immediate cause. Enter Underlying Due to (or as a consequence of) 3 The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician are use as the buriar Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō 5 Other (specify) Month Dav Year Pregnant at time of death signed by the ar Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by RUSEPSIS Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s performed' Yes 2 N Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1/ Natural 5 Pending 1 \sum Yes 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number မ 29d. Date signed (Month, Day, Year) 10 0285 sugger 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1525 State Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>012</u> Physician/ Geraldine Earl Hillman July 6 P^{M} 3:07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Frederic Hospital Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 434-18-8760 92 1 🗆 M 2 🔀 F **Director** 04/02/1920 Louisiana Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director MD Frederick Frederick 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 1900 Rosemont Ave. 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces 2 1 Yes 2 No Black, White, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Administrative Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 John G. Hoyt Faye Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8613 Discovery Blvd., Walkersville, MD 21793 Helen Sheppard / daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Stauffer Crematory 7/9/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21, Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 Jayulu MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physiciani Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner nabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner attending physician and I for use as the burial-transit 1 pertension that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregna in the past 12 mo Month Vear Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò avkinsan 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No 1 Inpatient 2 DER/Outpatient 3 IDDOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

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State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Ye

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Dr

Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2/9, June 20°1′2 9:07 A Nancy Jean Hoffman Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Mt. Airy Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🏲 F Months Davs Hours Min 219-44-4718 66 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified a MD 1 X Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7947 Yellow Springs Rd. 21702 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sales Associate retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Hoffman, Sr. Catherine Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Hoffman, Jr./brother 9544 Dublin Rd., Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gar. 07/03/2012 Frederick, MD ture of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Deat Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) £xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• La hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit minutes Due to (or as a consequence of)
Encephalopathy 9/00 Physician/Medical dous Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify) Hospital 1 🗌 Yes 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 NID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 468 Johnson Drive umas

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month.

strar's Signature

Registrar

ANMANGANDLA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JUL 1 0 2012

DOO 26064

07-06-2012

10583-THEODORE GREEN BLVD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tim Month Physician/ 2:32 PM Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omic If Under 1 Year If Under 2 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) 22-006 Director 1/**X**M 2 □ F VI RGINIA 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, Ite Mental Experience must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 15 Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? APT Funeral 203 2180 ted 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Abover Grm work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hollingn Times 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2 i 804 19a. Informant's Name/Relationship (Type, Print) DR Holl, (wire 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 19 Burial 2 Cremation 3 Removal from State Parksley UHARTON Cem -11-12 4 Donation 5 Other (Specify) WHATE nature of Funeral Service Licenses 22. Name and Address of Facility (): ACCOMAC 23301 Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ CARDIOUNYOFATH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events siclen end burlel-transit Exami Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physicien funeral director, page 2 should be detached for use as the burle Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 24 hours after death.
Funeral Director: After this certifics etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPI 47 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 14 Natural work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3—Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN3 120 eru WAR 31. Date filed (Month, Day, Year) State JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Roland Clayton Haggins, III State of Maryland / Department of Health and Mental Hygiene 2012 23593 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month D. July 1, 2012 **Medical Examiner** 0754 hrs Roland Clayton Haggins III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1501 Cabin Branch Drive Landover If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director 1 M 2 F 578-94-9115 1965 46 Nov.25 DC Usual Residence of Decedent ij 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No or 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
nnt: If item 27 is marked other than "natural", or items 23s nr 78 - 6 ato , or items 23a or 28a-f shor, must be notified at once DC Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SE, United States 4665 Benning Road, Unit 20019 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black other than "natural", <u>۾</u> or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private 12 Warehouseman Com 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Haggins Jr Johnson Betty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4665 Benning Road, SE, Washington, DC 20019 Veleda M. Williams-Haggins 20c. Location - City or Town, State 20a. Method of Disposition 1 X Bun'al 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/7/12 Suitland, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Hodges & Edwards F.H. 21 Signature of Funeral Service License 3910 Silver Hill Rd., Suitland, MD. 20746 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and Medical Death a. Head Injuries Complicated by Traumatic Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and for use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown this certificate has been I director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Com ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 2 No 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jun 28, 2012 building collapsed on subject 1 Natural 1500 hrs 5 Pending 1 ✓ Yes 2 No Director: d in by the f 2 🗹 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 1501 Cabin Branch Drive, Landover, MD within 24 hours a

To the Funeral I (Specify) Warehouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. July 2, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Regist ar's Signature 20 Year) State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KATHRYN SUE MAY HARRIS JUNE 24 2012 10:10AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT HEARTFIELDS EASTON Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Rirth **Director** 215-26-7302 83_{Yrs.} 1 □ M 2 X F MAY 25, 1929 Usual Residence of Decedent MARYLAND 28a-f show ems 23a or 28a-f show r must be notified at 10b. County with the Maryland 10c. City, Town or Location Director TALBOT EASTON 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 PORT STREET, BUILDING 100 21601 USA permit, Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 SPECIAL EDUCATION TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ELEEN PASOUITH ERNEST FORREST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROGER B. HARRIS, III, SON 27663 EQUESTRIAN DRIVE, SALISBURY, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) CHESTER CEMETERY 6/30/2012 CHESTERTOWN, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 MHOL K MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ enelprovoccular disease or condition Medical resulting in death) **Examiner** chanical valve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month signed by the at id be detached for Pregnant at time of death Day Year 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Atrial Abrillation, condionny apath 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 performed? Yes 2 No 1 Tes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Supnan

Registrar DHMH 17 Rev 06-2011

State

TUS

ess of person who completed cause of death (Item 23a) (Type, Print)

508 Idlewild

57860

Avenue

June 26, 2012

Easton, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOR	Department of Health a		20	12 23595		
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea		3. Time of Death		
	Physicia		Catherine M. Hooper		Month	10 Day 2012			
and the same	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	of Death	4c. County of I			
تمبيد			4901 Roundhill Road	Ellicott		Howar			
	Funeral Director		5. Social Security Number 215-22-4287 6. Sex 1 □ M 2▼ F 86	Months Days Hours	Min. (Month, Da	y, Year)	Birthplace (State or Foreign Country)		
	*		Usual Residence of Decedent	Yrs.	02/08/	1926	MD		
	ryland -f show ied at	ctor	10a. State 10b. County 10c. City, Town MD Howard ELL	or Location Licott City			10d. Inside City Limits 1 ☐ Yes 2X No		
	or 28a	Dire	10e. Street and Number	10f. Zip Code		10a. Citizen of Wha			
	with t	Funeral Director	4901 Roundhill Road	21043		United	States		
	death r items ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)		American Indian, White, etc.		
036	be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by	1 ★ Never Married 2 Married 1 Yes 2 ★ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify:	White		
2-0	2 hour "natul	plete	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most	t of working	16b. Kind of Busin	ess/Industry		
121	ithin 7; ene. • than he Me	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisor State of							
d 2	iled will Hygid other	Be	17. Father's Name (First, Middle, Last)		er's Name (First, Middle,	Maiden Surname)			
ylar	ld be f Menta arked atic ev	ပ္	Eugene L. Hooper, Sr.		nerine M. M				
Mar	and 2 should be fill Health and Mental tem 27 is marked on ther traumatic eve	15	T	. Mailing Address (Street and Number 4 Oak Spring Driv			e, Zip Code) 21060		
ر ا	f Healt f Healt item 2 other		20a. Method of Disposition 20b. Place of	Disposition (Name of	Date	20c. Location - Cit			
E C	Page 1 ment of ant: If it ury or o		De Bullai 2 - Clemation 3 - Removal nom State	y, crematory or other place) on Park Cem. 0	7/13/2012	Baltimo	ore, MD		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho appropriant: If item 27 is marked other than "natural", or items 23a or 28a-f sho appropriately injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licensee Shew Collins - With the	22. Name and Address of Facilit					
	002 60		23a. Part 1. Enter the disease, or complications that caused the death. Do n	4112 Old Columb			Approximate		
4	Hysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	VICE			Interval Between Onset and Death		
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of	1 - 41			1		
	Lamine	er	Sequentially list conditions, b	Ton			1 year		
	ted I	Examiner	cause. Enter Underlying Cause (Disease or injury	en)					
	ate be executed hysician and the burial-transit	I Ex	that initiated events resulting in death) Last Due to (or as a consequence of	of):					
90	the Hospital or Attending Physician: The law requires that the death certificate be executed that A hours after death. the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	edical	d						
687	eath certificat attending ph d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of	of delivery		
Box 687	death c e atter ed for u	Physician/Me	in the past 12 months? 1 Yes 2 No 1 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)		Month	n Day Year		
P.O.	requires that the der been signed by the s should be detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part	l. 23e Did t	obacco use contribu	ute to the cause of death?		
S, D	signed d be d	d by	, and a significant of the signi		1 🗆	11	☐ Probably 4 ☐ Unknown		
ord	v requ	Completed			24a. Was		re autopsy findings available or to completion of cause of		
Rec	Physician: The law this certificate has ral director, page 2	Jom J				ormed? dea	ath? Yes 2 No		
tal	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)				
Ž	Physic r this c	<u>ان</u>	1 Inpatient 2 ER/Ou 27. Manney of Death 28a. Date of injury 28b. T	itpatient 3 □ DOA □ 4 □ No Time of □ 28c. Injury at	ursing Home 5 Resi	dence 6 🗌 Other (a	Specify)		
o uc	nding ath. r: Afte	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) ii 2 ☐ AccidentInvestigation	njury work? M 1 \(\sum \) Yes 2 \(\sum \)					
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	rm, street, factory, office	28f. Location (City or Tov		or Rural Route Number,		
۵	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and	place, and due to the c	ause(s) and manner	as stated.		
	n 24 h n 24 h se Fun pletely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my know	r investigation, in my opinion, death or	ccurred at the time, date	and place, and due to	the cause(s) and manner stated.		
	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number	_	29d. Date signed (A	Month, Day, Year)		
			Man telle MV	1 d 346	5	11 ppu	1012		
6	•		30. Name and address of person who completed cause of death (Item 23a) (Steven Geller, MD 8186 Lark B	Brown Road Elkri	idge, MD 2	1075			
	Sta Registr		31. Date filed (Month, Day, Year) JUL 11 2012 32. Begistrar's Signature	Sparke					
	. Iogioti		/ / /ot	(7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Physician/ 7:15AM 10 William L. Harms Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchester Cambridge <u>700 Water Street</u> Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) **Director** 570-30-2515 1 🔀 M 2 🗆 F 8/27/1926 CA 85 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Cambridge Dorchester MD 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 700 Water Street , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married Completed by 1 Ves 2 No 1944 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify. Specify: "natural", 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Law Enforcement Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Irene Jurod Leslie W. Harms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Cambridge, MD. 21613 700 Water Donna Harms/wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Midshore Cremation 7/11/2012 Cambridge, MD 21. Signature of Funeral Service Licensee 308 High St. Cambridge, MD Newcomb&Collins_FH 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximate Interval Between Onset and Death Immediate Cause (Final Physicany disease or condition resulting in death) Medical AD OJASCULAR **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ monAl Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of death?

1 Yes 2 No autopsy performed? Yes 2 D No has page 2 After this certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: filled in by the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check

31. Date filed (Month.

title of certifier

a

ous

32. Registrar's Signature

29c. License number

H44615

compressed cause of death (Item 23a) (Type, Print) ranker St Canbridge MP

29d. Date signed (Month, Day, Year)

July 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month JULY 0:05 AM Honson 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL GLEN BURNIE 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day,) 1939 Days Min 219-38-7424 Director 1 M 2 T F Apr 73 iral", or Items 23e or 28e-f shov Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Odenton Maryland Anne Arundel 1 Tyes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 USA 1212 Odenton Rd. Apt 311 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1X Never Married 2 Married "netural", or Maryland 21215-0036 1 Yes 2X No Specify. Specify: Black. 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health end Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Mengines. Crofton Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Dietary Supervisor Convalescent CTR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henson Gertrude Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Johnson Grove Lane Crownsville, Md. Barbara Godard (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State John Wesley UMC 7-7-12 Crownsville, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 柳mame 和母母seof MilitSons Mortuary, Annapolis, 21401 1922 Forest Dr. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 it4393449 disease or condition **SMEEKS** Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlyin Cause (Disease or injury Due to (or as a consequence of) ettending physicien and I for use as the buriel-transit the Hospitel or Attending Physician: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 1 Yes 2 No To the Hospitel or Attending Physician: The lew requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director: page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No |၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 6 Millonne Jusé Giónpoco MO P1F5000 2004 3 3013

Registrar

DHMH 17 Rev 06-2011

State

HEASON

301 Hospital Drives 6 Don Burnie, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUILLERMO JOSE CIANCHECO

31. Date filed (Month, Day,

Keith Raymond F		1- For State OF DE PET FH	al Hygiene	-	2 2359
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Last) Keith Raymond Hanson	2. Date of Dea Month July 1, 20	nth Day Year	3. Time of Death 1000 hrs
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital 4b. City, Town, or Location of I	Death	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 F 39 Yrs. Months Days Hours	8. Date of Bir Min. 1/25/1	th(MM/DD/YYYY) 9. Bir L 9 7 3 Foreig Co	
/land -f show any once.	tor	Usual Residence of Decedent 10a. State		0g. Citizen of What Cou	10d. Inside City Limits 1 Yes XX No
h the Mary 3a or 28a	Director	10e. Street and Number 2415 Falcon Point Drive 10f. Zip Code 750		USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 No 1 Yes 2 No 1 Y	uerto Rican, etc.)	White, etc. Specify: Wh:	
036 thin 72 hours ne. r than "natur ledical Exam	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Lt. Commander		16b. Kind of Business/ US Nav	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	B	James D. Hanson Mary	Name (First, Middle, I Ann Wald	<u> </u>	
MD 2. Ad 2 should lith and M m 27 is m.	욘	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 2415 Falcon Point D	rive Fris	sco. TX 750	34
MOFE, Pages 1 an ent of Hea nt: If ite		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National	10/15/12	20c. Location - City or Arlington,	
Baltil permit. Departm Imports injury o		21. Signature of Funeral Service Licensea 22. Name and Address of Facility 12. Ridgely Ave.	Annapolis,		
Physician // /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardialiure. List only one cause on each line. Immediate Cause (Final disease	liac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b.			
ıt T	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
execu an and	ical	UNPENDED AMENDED #4b, per me, g930 8-14-12 sm			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	regnancy	23d. Date of delivery	Day Year
C. BO; the death by the att		Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1. 23e. Did to	bacco use contribute to	the cause of death?
cords, P.O. Box 6 Jaw requires that the death cer has been signed by the attendi should be detached for use	sted by		24a. Was	an 24b. Were au	ably 4 Unknown topsy findings available
tal Recorian: The law recrificate has bestor, page 2 sh	Completed	25. Was case referred to medical 26.Place of Death (CI	1 ✓ Yes	rm <u>ed</u> ? death?	ompletion of cause of
Vital hysician this cert	To Be	eyaminer?	lursing Home 5	Residence 6 Other	:
Division of Vital Rec pital or Attending Physician: The I cours after death. reral Director: After this certificate I filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury 28b. Time of Injury 22c. Injury at Work? 1 Yes 2 ✓ No.	o Driver in aut	how injury occurred to/auto collision	
Division pital or Attentours after death eral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street	or Town, S	Street and Number or Ru State) d and First Colony Bo	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.		and place, and due to th	e cause(s)
0.8	≊	29b. Signature and title of certifier 29c. License number O.C.M.E.		July 3, 2012	un, vay, rear)
431	Ī	10. Name and address of person who completed cause of death (Item 23a) Larbn Locke MD. Assistant Medical Examiner 900 W. Baltimbre Street, Baltimb	re, MD 21223		
Sta Registi	_	31. Date filed (Month 1949), 0-8 2013 32. Egistrar's Signature			
	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 2012 9:28 P M DANIEL JACK ILLARI Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 4809 MAIN STREET GRASONVILLE 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days Hours 215-58-3275 1 X M 2 □ F Director 59 05/18/1953 MARYLAND Usual Residence of Dece 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 1 Yes 2X No QUEEN ANNE'S GRASONVILLE MD 10g. Citizen of What Country? 10e. Street and Number ō Funeral 23a Page 1 and 2 should be filed within 72 hours after death with UNITED STATES 4809 MAIN STREET 21638 items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or item I Examiner n 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural"; Completed 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. If item 27 is marked other than "natur r other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEERING TECHNICIAN LOCAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ DANIEL ILLARI JEAN GNEGY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER ILLARI / WIFE 4809 MAIN STREET, GRASONVILLE, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. STEVENSVILLE CEMETERY 07/10/2012 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD FELLOWS, HELFENBEIN 106 SHAMROCK ROAD, (N & NEWNAM FUNERAL CHESTER, MD 21619 HOME, P.A. Ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Levicema disease or condition へんへか Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Line of death in the past 12 months?

1 Yes 2 No Month Day Year should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed' safter death.

Director: After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 1 Natural work? 5 Pending 2 🔲 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

2540

32. Registrar's Signature

CENTREVILLE ROM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UKENS

SI. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				aryland / D <i>ر</i>	epartment of Hea Ce <i>rtificate of Dea</i>	alth and Me ath	ental Hygie Reg.	ne 2012	23600		
	Physicia	n/	Registrar 1. Decedent's Name (First, Middle, Last) HELEN T. JORDAN		23.13410 01 204		2. Date of Death Month	Day Year	3. Time of Death		
	Medic Examin	al	HELEN T • JORDAN 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca	ation of Death	July 8,	4c. County of Death	4:40pm M		
and the	LAGITIT		Wilson Health Care Center		Gaithers	burg		Montgome:			
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 □ M 2 ☒ F 7. Age	(In yrs. last birtho		Under 24 Hrs. 8 ours Min.	B. Date of Birth (Month, Day, Yea April 23	1918 Penn	olace (State or Foreign try) Sylvania		
	and show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits		
	Maryla 28a-f	irect	Maryland Montgomery	Gaith	ersburg				1 ☐ Yes 2 🔀 No		
	with the s 23a or ust be r	Funeral Director	10e. Street and Number 9701 Fields Road #402		10f. Zip Code 20878	3	U1 U1	Citizen of What Cour nited State	tted States		
Airmed Follows							fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.		
Baltimore, Maryland 21215-0036	thin 72 hour ene. than "natu he Medical	The part of the pa						16b. Kind of Business Industry Own Home			
land 2	d be filed wi Aental Hygiu Irked other Itic event, t	To Be (17. Father's Name (First, Middle, Last) Ezydor Dugan				First, Middle, Maid Krenzel	den Surname)			
, Mary	nd 2 should ealth and N m 27 is ma eer trauma		19a. Informant's Name/Relationship (Type, Print) Carol Jordan (Daughter)	19b. 1	Mailing Address (Street and N	Number or Rural F ad #508 (Route Number, Cit Gaithers!	y or Town, State, Zip (burg, MD 2	0878		
imore	. Page 1 ar ment of He tant: If iter jury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of I cemetery. Gate of	Disposition (Name of crematory or other place) E Heaven Cem.	Ju1y 201	$\begin{bmatrix} 14 & 14 \\ 2 & 14 \end{bmatrix}$ S	c. Location - City or To ilver Spri	ng, MD		
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licenses (MO1	116)	22. Name and Address of 10 East Deer	FacilitDeVol	Funeral	Home ersburg, M	D 20877		
1	Physician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	the death. Do no	at enter the mode of dying, su	uch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death		
	Medical Examiner			consequence of):						
-	Usi ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):						
0	cate be executed physician and sthe burial transit	edical Exa	that initiated events C.	consequence of):						
876	rtificate ing phy e as the	/Medi	IF FEMALE:						-		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are or death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burian transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of deliv Month	Day Year		
ds, P.O.	luires that the signed by all de detail	by	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause given in	n Part I.		co use contribute to to	ne cause of death?		
Division of Vital Records,	r sician: The law rec s certificate has bee lirector, page 2 sho	Completed					24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of 2 No		
/ital	sician: s certific lirector,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	ont 2 EP/Out	Other	of Death (Check of		e 6 Other (Specific	d		
on of	il or Attending Physician: The la ar er death. Director. After this certificate ha ii by thε funeral director, page	icate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injunction (Month, Day)	y 28b. Ti	me of 28c. Injury at jury work?		3d. Describe how i				
ivisio	lor Atte arerdea Director	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injubuilding, etc		n, street, factory, office	21	8f. Location (Stree City or Town, S	et and Number or Rura State)	Route Number,		
	To the Hospital or within 24 hours at a to the Funeral Director Completed filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e: only one) 3 Certifying Nurse Practioner: To the	xamination and/or	investigation, in my opinion, de	leath occurred at the	he time, date and p	place, and due to the ca	use(s) and manner stated.		
	To # Withi		29b. Signature and title of Friffer	6	29c. License nun	mber 0 1 4 8	29d	Date signed (Month,	Day, Year)		
			30. Name and address of person was completed cause of d	eath (Item 23a) (T	Print) Russell	Avr	Gzithe	aprice V	N .		
	Sta Registr				arked.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ July 2012 S. Jones 7:30 p.M Henrietta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2711 Hillside Court Frederick Ijamsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 054-16-6447 89 **Director** 1 □ M 2 🗓 F 08/30/1922 New York Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f Frederick 1 Tes 2 X No Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral United States 2711 Hillside Ct. 21754 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status er than "natural", or ite Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Vice president Banking other of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Stitt Leota Van Keuren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Hillside Ct., Ijamsville, MD 21754 Clair Pirnia / granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State 7/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee pay MO1222 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 000 Immediate Cause (Final 791 Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to in media cause. Enter Underlying Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CIC 1 Tes 2 No 3 Probably 4 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page 2 After this certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2 X No 4 Nursing Home 5 K Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

24 hours after death. within 24 hor To the Fune completely f the

> Name and address Year! 32. Rigistrar's Signature JUL Registrar

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

36421

29d. Date signed (Month, Day, Year)

Medical

29a. Certifier

only one

29b. Signature and title of certif

12-04612 La'Bryan Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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1- For Stat Registrar	e		Certificate	of Deat	th		F	Reg. No.	- 0 1	
Physician/ 1. Deceder	nt's Name (First, Middle,Last)						2. Date of De Month		ear	3. Time of Death
Medical Examiner La '	Bryan De	eonta Jo	nes				June 19,			0331 hrs
4a. Facility	y Name (if not institution, give	street and number)		4b. City,	Town, or Lo	ocation of Dea	th	4c. County		
Quee	en Anne's Emergency	Center		Quee	enstown			Queen	Anne's	
Funeral 5. Social S	Security Number 6. Sex	7. Age (In	yrs. last birthda	y) If Und	ler 1 Year	If Under 24H	rs. 8. Date of B	irth (MM/DD/YY)	1	
Director		M 2 F	0.4	Yrs. Month	ns Days	Hours M	in.	2 1001	Foreign Cour	(vnte
	3-31-5459 1X	141 2[1	21	113.			101-2	3-1991		M.a.
10a. State		10c.	City, Town or L	ocation					T	0d. Inside City Limits
~ 1 1										1 X Yes 2 No
Maryland 28a-f show d at once. 10e. Stree		nco		Sal I 10f, Zir	isbu	ry		10g. Citizen of V		
the Maryland or 23a-f sh lifted at once Director	et and Number			101. 21				rog. Cilizeri or v	VIIat Count	y.
in the Maryland 123 or 284-f show 123 or 284-f show 100 Stree 11 Wagilar 11 Wagilar 12 O O	0 W. Railro	ad Avenue			2180			USA		
Funer be no state of the state		12. Was Decedent Ever	in U.S. 13				Specify Yes or N to Rican, etc.)		ce - America ite, etc.	an Indian, Black,
death w must be I Mer	ver Married 2 Married	Armed Forces?	No	ii res, spec	ny Cuban, n	VIONICALI, I GOI	to Mount Cto.		110, 010.	
by H	dowed 4 Divorced	If Yes, Sive Year or Dates:	1	Yes 2	No No	specify:		Sp ecif y	: B]	ack
15. Dece	edent's Education (Specify on			edent's Usual				16b. Kind of E	Business/In	dustry
within 72 hour within 72 hour piece. Modical East at the completed on pleted tary/Secondary (0-12)	College (1-4 or 5+)	durii	ig most of wo	aking ille, L	O NOT USE	etil eti)				
D36 thin thin ne.	10		Fa	ctory	Wor	ker		Per	rdue	
17. Father	's Name (First, Middle, Last)				18	Mother's Nar	ne (First, Middle	Maiden Surnan	ne)	
21215-0036 In Mental Hygiene. The Mental Hygiene. The Medical Examiner 112. Dece Completed by I also into the Medical Examiner I	lbert Cla	yton Jo	nes		7	Annet	e Mar	rie Ca	nnon	
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Anne	ette Cannon	/ Mother	3	06 Gr	ant S	Street	.Seaf	ord,De.	199	73
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental 1 ind: If item 27 is marked or other fraumatic event, To Be To Be To Be To Be	od of Disposition		20b. Place of Di	sposition (Na	me of ceme		Date	20c. Location		
1 K Bui	rial 2 Cremation 3	Removal from State	=	or other place		_	- 20 11	, , , , , ,		
Page 1 Pa	nation 5 Other Specify:		Odd F	ETTOM	s Cer	n. U	0-30-12	Seafo	ra,D	e.
0 E 6 E E	ture Funeral Service Licens	7 1		22. Name and	a Address o	Be Be	ennie S	Smith F	uner	al Home
E.E.O.S.	I. Enter the disease, or compl	1001	1	437	Eroni	t st.	Seafor	d, De	1997	Approximate Interval
failur	 Enter the disease, or complete. List only one cause on each 	ications that caused the ch line.	death. Do not er	iter the mode	or ayıng, sı	ucri as cardiad	or respiratory a	rrest, shock, or r	leart	Between Onset and
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or condition	on resulting in death)	Due to (or as a conseque	nce of):							
Sequentia	ally list conditions, b.								_	
if any, lea	iding to immediate [nter Underlying Cause]	Oue to (or as a conseque	nce or):							
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68760, certificate by the bunding physical control of the control	decedent pregnant in the 12 months?	1 Live birth		Fetal death	3	Ectopic preg	nancy	Month	Da	ay Year
		4 Pregnant at time	of death 5	Other (Spe	ecify)			Į.		
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O at the part II. Ot	ther significant conditions	contributing to death but	not resulting in	the underlyin	g cause giv	en in Part I.				ne cause of death?
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has b 2 sh —							per	opsy formed?	death?	mpletion of cause of
The page								2 No	1 Yes	2 No
Committee Continue Committee Continue Committee Continue	case referred to medical	7.1				of Death (Chec	, ,	7		
To large this of the state of t		lospital: 1 Inpatient	2 🗹 ER/Outpa	tient 3	DOA O	other Nur	sing Home 5	Residence 6		N.
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			State of Maryland / Dep		Mental Hygiene	2 22603
			riogica di	rtificate of Death	1	2 23603
	Physicia	in/	1. Decedent's Name (First, Middle, Last) Dimitrios G. Kousoulas		2. Date of Death Month 7/3/12 Year	3. Time of Death
	Medic Examin		Dimitrios G. Kousoulas 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	10:15 A ^M
	Examin	ier	6252 Clearwood Road	Bethesda	Montgome	
11-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		irthplace (State or Foreign ountry)
	Director		132-28-0103	1	12/22/1923	Greece
	and show	٥	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Maryli 28a-f stifiec	rect	MD Montgomery Bethesda	a		1X Yes 2 ☐ No
	th the	Funeral Director	10e. Street and Number 6252 Clearwood Road	10f. Zip Code 20817	10g. Citizen of What C	
	ath wit ms 2; must	ner		Was Decedent of Hispanic Origin? (Sp.		
ထ	er des or ite miner		Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Am Black, Wh	
Ö	ırs aft ural", I Exal	Completed by	3 Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ♣ No Specify:	Specify: Wh	ite
15-(72 hou "nat edica	ple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b. Kind of Busines	s/Industry
7	/ithin iene. r thar the M	Con		O NOT use retired)	Education	ı
b	filed val Hyg	Be o	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname)	
Maryland 21215-0036	Menta	은	George Kousoulas	Barbara	a Kalergis	
Mar	2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at			ng Address (Street and Number or Rur 1 ${ t Cairn \ Terrace \ Be}$	al Route Number, City or Town, State, 2	Zip Code)
	and Heal em		20a. Method of Disposition 20b. Place of Dispo	osition (Name of	Date 20c. Location - City of	or Town, State
o E	Page 1 nent of ant: If it ury or o		Bullar 2 Diemator 3 Diremoval nom State	matory or other place) Heaven Cemetery	9/2012 Silver Spr	
Baltimore,	permit. Page Department of Important: If any injury or once,	3	July 1		eph Gawler's Sons	
<u></u>	20 E # 9		William K. Dugge 5	130 Wisconsin Ave	NW Washington DC	20016
	and the second wave		23a. Part 1. Enter the disease, or complications that daused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arrest,	Approximate Interval Between Onset and Death
- F	Medical		disease or condition resulting in death) Congestive Heart Due to (or as a consequence of):	Failure		Onset and Death Months
	Examiner		Renal Failure			6 Months
	= =	iner	Sequentially list conditions, if any, leading to immediate cause. Emer underrying			
	and and	xan	Cause (Disease or injury that initiated events resulting in death) Last c. Prostate Cancer Due to (or as a consequence of):			1 Year
0	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial transit	dical Examiner	, , ,			
8760	ificate ig phy as the	Medi	IF FEMALE:	,		
89 X	th cert tendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?		23d. Date of d	
Box	the atter	Physician/Me	1 ☐ Yes 2 ☐ No	Other (specify)	Month	Day Year
0.4	aw requires that the las been signed by the 2 should be detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
8	puires i en sign	ed b	Deep Venous Thrombosis		1 ☐ Yes 2 ☐ No 3 ☐	Probably 4X Unknown
Vital Records,	aw rec as bee 2 sho	Completed	Myocardial Infarction		24a. Was an 24b. Were a autopsy prior to	utopsy findings available completion of cause of
e Re	The ate h page	Con			performed? death? 1 Yes 2 No 1 Yes	es 2 😾 No
Ita	certifi rector	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec		
o to	ding Physician; The h. After this certificate funeral director, pag	e: <u>1</u> 0	1	nt 3 □ DOA 4 □ Nursing He f 28c. Injury at	ome 5 🔀 Residence 6 🗌 Other (Spe 28d. Describe how injury occurred	ecify)
Ou	ending sath. rr: Afte he fun	ficat	1 X Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
Division of	or Atter frer de lirecto in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or R City or Town, State)	ural Route Number,
٥	or the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place a	and due to the cause(s) and manner as	stated.
	n 24 h	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, deam only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred a	t the time, date and place, and due to the	e cause(s) and manner stated.
_	Voithi Soral		29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
	15		I m Wy	D39947 MD	July 6, 20)12
			30. Name and address of person who completed cause of death (Item 23a) (Type, I Mona Ellis, MD 5530 Wisconsin Avenue		hase. MD 20815	
	Stat	te	31. Date filed (Month, Day, Year) 11 1 0 2012 Registrar's Signature			
	Registra	ar	111 10 2012 Person p. 19th			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 0 Physician/ July 2012 Erena R. Knapp 8:45 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Harmony Hall . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year, Months Hours Country Director 577-52-4633 1 M 2 X F 86 Usual Residence of Decedent 06/03/1926 Brazil 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Columbia MD Howard 23a or 10e. Street and Number 10g. Citizen of What Country? Funeral United States 6336 Cedar Lane #109 21044 marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1. Marital Status 14. Bace - American Indian. Armed Force Black, White, etc þ 1 Never Married 2 Married Yes 2 X No 1 L Yes ₁
If Yes, Give White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 🔀 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Else Tronicke Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6336 Cedar Lane #109 Columbia, MD Thomas Reedy - Executor 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 07/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD Cremations Ardent 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Manuto 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical use as F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 XNo Pregnant at time of death Year the hed 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate 2 X N Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence $ag{1}$ Other (Specify) Assisted 1 Yes 2 XNo ပ 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28h Time of Within 24 hours after occur.

To the Funeral Director: After the funeral Director and the funeral Director and the funeral Director and the funeral Director and the funeral Director and D Certificate: 28d. Describe how injury occurred Living 1 X Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: In the basis of examination allows involved and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse fractitioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who comp

31. Date filed (Month

Andrew Lazris, MD

2012

Barks

eted cause of death (Item 23a) (Type, Print)

aistrar's Signature

6334 Cedar Lane #103

29c. License number

D47447

Columbia, MD

29d. Date signed (Month, Day, Year)

21044

July 11, 2012

12-04926 Joseph Koltko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 23605

		1-For State Certificate of L	Death	,,,	Reg. No	0.	2 2000
Physicia	_	1. Decedent's Name (First, Middle,Last)		2. Dat Mor	e of Death		3. Time of Death
Medical Examii		JOSEPH HARRY KOLTKO		July	y 1, 2012 ´		1401 hrs
		ta. I dollay realise (ii not included)	City, Town, or Locat	tion of Death	ľ	4c. County of Death	
		Onion Monoral Noophar	Baltimore			BALTIMORE	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		loure Min		M/DD/YYYY) 9. Birt Foreig	n
Director	- 1	212-60-1573 1 X M 2 F 58 Yrs.	Monaro Bayo 71	1	1/17/1	953 cou	Intry)BALTIMORE
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
w any	1	10a. State 10b. County 10c. City, Town or Location	ı				1 Yes 2 No
aryland 8a-f show at ooce.	Ö	MARYLAND PRINCE GEORGES HYATTSVILLE			140: 0	Citizen of What Coun	
Mary 7.28a.	Jec.	10e. Street and Number	10f. Zip Code		10g. C	Itizen or vynat Coun	u y r
ith the Maryland 23a or 28a-f sho notified at 90ce.		7710 2 2 0 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	20784	0:::0:0		TED STATE	
th wit	Funeral Director	1 Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic , specify Cuban, Mex			14. Race - Americ White, etc.	can indian, black,
r dear	ᆵ	1 Yes 2 X No	es 2 No spe	acifu:		Specify: WHI	TE
nral"	<u>a</u>	A nr Dates:	Usual Occupation (C		ne 16b	, Kind of Business/Ii	ndustry
2 hour	100	during mos	t of working life. DOI	NOT use retired)			
136 hin 7. e. e.	ם	r Orthinal	- HVAC C		H	EATING &	AIR CONDITE
d with	Completed	17. Father's Name (First, Middle, Last)		other's Name (First,	Middle, Maide	en Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c evect, the Medica	Be (NICHOLAS KOLTKO		NNA WINTE			
			ddress (Street and				Zip Code)
MD id 2 sho lith and in 27 is			. PRINCES				
ore, Nes 1 and of Health If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State CHESAP LAKE			200	c. Location - City or	Iown, State
MOFC Pages 1 tent of F		4 Donation 5 Other Specify: CENTER	CREMATION	7/5/20)12 S	TEVENSVII	LE, MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1		me and Address of Fa			S BY FELLOW	
E E E E	5 2		MARINS VIERNE	AN CREMATIC	NS & FUN	TERAL CARE	
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter that failure. List only one cause on each line.	Sanda Graying, Budh	las calvandado de do	iatolyla) resto	or heart	Approximate Interval Between Onset and
Medical. Examiner	1	Immediate Cause (Final disease a Complications of Head Injuries					Death
		or condition resulting in death) Due to (or as a consequence of):					
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
-1 -140V	흘	Course Enter Underlying Cause (Disease or injury that initiated					
sit d	Examine	events resulting in death) Last Due to (or as a consequence of):					
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60, ate be ex shysician	Medical	UNPENDED AMENDED			T.		
376 ficate g phy s the t	Š	F FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	I death 3 E	ctopic pregnancy	4	23d. Date of delivery Month	ay Year
K 68	흥	past 12 months? 4 Pregnant at time of death 5 Othe	r (Specify)				
Box 687 e death certific the attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown					
od by estache	by P	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given	in Part I. 2		co use contribute to	
Division of Vital Records, P.O. ral or Attending Physiciae: The law requires that the star clear. A Director: After this certificate has been signed by led it by the funeral director, page 2 should be detach	8						ably 4 Unknown
rds v requ	Completed				4a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
ecc he lav ate ha	E			1[performed Yes 2 ✓		s 2 No
E T E T T T T T T T T T T T T T T T T T		25. Was case referred to medical		eath (Check only or			
Vita ysici this co	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	3 DOA Othe	Nursing Hom	ne 5 Resi	idence 6 Other	
of Ph		27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year)		Subje		injury occurred or of motorcycle	involved in
Sion Attendi death. ctort y the fi	읥	2 Accident Investigation		² No collis	ion		
NiS o Ai ferd Direc	읡	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building		r Town State))	ral Route Number, City
pital Di	Certification:	4 Homicide determined (Specify) Major Road / Highway				th of Rt. 197, Laur	
e Hos		29a. Certifier (Check only one) Quantifier (Check only one) Wedical Examiner: On the basis of examination and/or investigation	ed at the time, date an	nd place, and due to	the cause(s)	and manner as state	ed e cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital of Attending Physicino: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director.	Medical	and manner stated.	29c, License nur			d. Date signed (Mo	
	2	29b. Signature and title of certifier	O.C.M.E			uly 2, 2012	,,
8 N		My Brall, Old					
de 13		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	Baltimore Stree	et. Baltimore. M	1D 21223		
	ole	22 Belietrade Cianature					
Regist	ate	31. Date filed (Month, Day, Year) 6 2012 32. Registrar's Signature	Med				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOANNE F. KANGAS July 2012 6:30 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice Care Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 002-28-6195 Director 1 M 2 XF 73 Yrs. August 11,1938 Mass. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minordant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Edgewater Direct 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3550 South River Terrace 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify SpecifWhite 3XXWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Deeb G. Henev Florence Giletti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Ceresi/Daughter 2371 McKenzie Road, Ellicott City, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Md. Veterans Cem 7-6-12 Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas, Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final 33 set and Death Physician/ METASTASI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 2.24 hours after death.

2.4 hours after death.

Permeral Director: After this certificate has been signed by the attending physician and leitely filled in by the Intread director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 200 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check Certifying NO only one e Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 201 10 Hour Amotheris mo 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e tare of Maryland Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ 6.43PM Wayne Kline Thomas Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Washington 4b. City, Town, or Location of Death **Examiner** Hagerstown Meritus Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 212-50-8792 64 1**X** M 2 □ F Director 4/11/1948 Wisconsin Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State Examiner must be notified at Director 1 XYes 2 No Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **456 Gilf** c ö U.S.A. Funeral 21740 "natural", or items 23a Gilford Avenue death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Draftsman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vina M. Simpson ည Albert B. Kline, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17312 Cloverleaf Road, Hagerstown, MD 21740 Albert B. KLine, Jr. / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown, Maryland 7/17/2012 Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel uneral Sen ice Signature ense 1601 Pennsylvania Ave., Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ Marcolo disease or condition resulting in death) Medical Due to (or as a conse due ce of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of if any leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work'?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 7/16/2012 Signati ed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Rd#223 Hagerstown, MD 21740

Registrar DHMH 17 Rev 06-2011

State

SHERIF

		1	For State Registrar	,	epartment of Health Certificate of Death		lene 2012 23609
	Physicia	n/	Decedent's Name (First, Middle, Last)	reda	LEVIN	2. Date of Death Month July 8	3. Time of Death
	Medic Examin		la. Facility Name (if not institution, give street and Holy Cross Hospital	number)	4b. City, Town, or Locatio	n of Death	4c. County of Death Montgomery
	Funeral Director	5	6. Social Security Number 6. Sex 1 □ M 2 🖟	7. Age (In yrs. last birthda 94 Yrs	Months Days Hours	8. Date of Birth (Month, Day, Oct. 26	
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
	e Mary r 28a-f notifie	Direc	Maryland Montgomery 10e, Street and Number	Sil	ver Spring		1 Yes 2 No
	s 23a o	Funeral Director	515 Apple Grove Road	1	20904		United States
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Rem 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 If Yes	d Forces? Yes 2 A No	13. Was Decedent of Hispanic 0 If Yes, specify Cuban, Mexic 1 ☐ Yes 2 🛣 No Speci	can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	72 hou n "natu fedical	Completed	15. Decedent's Education (Specify only highest grade comple	ited) (G	ecedent's Usual Occupation live kind of work done during m e, DO NOT use retired)	ost of working	16b. Kind of Business/Industry
212	within giene. er thai t, the N	Sol	Elementary/Secondary (0-12) Collect	je (1-4 or 5+)	Registered Nurs	se	Medical
and	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) Samuel Weiner		18. Mo	other's Name (First, Middle, M Bella Corr	faiden Surname)
Maryland	12 should lith and M 27 is mar r traumati		19a. Informant's Name/Relationship (Type, Print) Rebecca Burka, Niece	19b. N 230	Mailing Address (Street and Num 1 Connecticut	nber or Rural Route Number, Ave., NW, #G0	City or Town, State, Zip Code) 10008 C, Washington, DC
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trae		20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cemetery,	isposition (Name of crematory or other place)	Date 07/11/12	20c. Location - City or Town, State Adelphi, MD
Balti	permit. Departri Importa any inju	Ī	21. Signature of Contral Service Licensee	- MO1008	Torchinsky Het	Prew Funeral I	Home
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of	hat caused the death. Do not in each line.			
	Medical		una di dia dia dia dia dia dia dia dia dia	herosclerotic	Cardiovascula	r Disease	Onset and Death
	Examiner	<u>_</u>	Sequentially list conditions, b.				
	Sit ted	amine	cause. Enter Underlying Cause (Disease or injury	e to [or as a conse_uence o]			
	icate be executed physician and is the burial transit	edical Examiner	that initiated events resulting in death) Last	e to (or as a consequence of):			
3760	ficate b g physia as the b		d				
. Box 687	law requires that the death certific has been signed by the attending p e 2 should be detached for use as		in the past 12 months?	, outcome of pregnancy Live Birth 2 ☐ Fetal death Pregnant at time of death Unknown	3		23d. Date of delivery Month Day Year
ds, P.O.	quires that then signed by ould be deta	ted by Pt	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause given in Pa		pacco use contribute to the cause of death? es 2 🕅 No 3 □ Probably 4 □ Unknown
Division of Vital Records,	The law ate has page 2	Completed				24a. Was ar autops perforr 1 Yes	prior to completion of cause of death?
/ital	rsician: s certific director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outp	Other:	Death (Check only one) Nursing Home 5 Reside	ence 6 Other (Specify)
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Teampletaly filled in by the funeral director.	icate: T	27. Manner of Death 28a. I	Date of injury Month, Day, Year) 28b. Tin inju	ne of 28c, Injury at	28d. Describe ho	w injury occurred
)ivisio	i or Atter after des Director d in by th	Certificate:	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, farm uilding, etc. (Specify)	n, street, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, , State)
	ne Hospita n 24 hours ne Funeral	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To Check only one) 3 Certifying Nurse Practiti	e basis of examination and/or i	eath occurred at the time, date a nvestigation, in my opinion, death edge, death occurred at the time,	occurred at the time, date an	d place, and due to the cause(s) and manner stated.
	To the within		29b. Signature and title of certifier	UL DO FAC	P 29c. License number H 45839	er 2	July 9, 2012
			30. Name and address of person who completed	cause of death (Item 23a) (Ty	_{pe, Print)} edar Lane, Suit	te #203C. Beti	nesda, MD 20814
	Sta Registr		Gary E. Raffel. D.O. 31. Date filed (Month, Day, Year) JUL 10 2012	39. Registrar's Signature	harles .		

	State of Maryland / Department of Health and Mental Hygiene Contificate of Death 2.0.1.2.2.3.6.1.0														
			Registrar	-		Certificat	e of L	eath			Reg. No.	<u> </u>	4	2301	
	Physicia	n/	Decedent's Name (First, Middle, Last)		-					Date of De	Day	012 Yea	ır	3. Time of Death	M
ic.j.	Medic		Lawrence 4a. Facility Name (if not institution, give stre		icas Jr		Town or	Location of	Death	July	7	O12 County of De		0020 A	
	Examin	er	Holy Cross Ho			4b. City,		lver S		3	40.0	Mont		ery	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birtho	ay) If Unde Months	r 1 Year Days	If Under 2		Date of Bir (Month, Da			Birthpla	ice (State or Forei	ign
	Director			M 2 □ F	61		Days	Hours			5, 195) OC	
	nd how at	칟	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	r Location			Joc	<u> </u>	J, 19.	70		d. Inside City Limi	its
	laryla 3a-f s ified	ect	Maryland Prince Geo	roe's				Laure	1					1 🔀 Yes 2 🗌	No
	the N		10e. Street and Number	7 8 5 1		10f. Zip	Code		_		10g. Citize	en of What	Countr	y?	
	n with	Funeral Director	11720 South Laurel	Drive #3	A		20	708			Uni	ted S	Stat	es	
	1 and 2 should be filed within 72 hours after death with the Maryland if health and Merital Hygiene. item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Walitar States	Was Decedent Ev Armed Forces?		13. Was Deced If Yes, spec	dent of His cify Cubar	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- ın, etc.)	14	4. Race - Ar Black, W			
36	al", o	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates.	10	1 🗌 Yes	2 🔀 No	Specify:			S	pecify:Af Ameri	ric	an	
ŏ	hours natur lical I	Completed	15. Decedent's Educ	ation	16a. D	ecedent's Usu	al Occupa	ation	of working			d of Busine		ıstry	
21	in 72 ie. han "	l mo	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	16	Give kind of wo fe. DO NOT us	e retired)								ŀ
2	d with hygier ther t	Be C	12th			Rol	lerc	over 1			14-1-1	Gove	rnm	ent	\dashv
auc	ntal F ced of	To B	17. Father's Name (First, Middle, Last) Lawrence Henry L	ucas Sr.				18. Mother	r's Name (Fil R111		elma				
Maryland 21215-0036	ould by mark		19a. Informant's Name/Relationship (Type		19b	Mailing Addres	s (Street a	and Number					Zip Co	nde)	
Š	12 sh alth ar 27 is rrtrau		Jacqueline Lucas			0	*				-			d. 20708	3
re,	1 and of Height Fitem		20a. Method of Disposition	16	20b. Place of I	Disposition (National Communications)		е) Т	Date		20c. Loc	ation - City	or Tow	n, State	
Ē	Page ment ant: I		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cremat		7	uly 7 201	12	Cli	nton,	_Ma	rvland_	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licensee	L -()		22. Name a		-	Deci			al Ho	-		
	TO = 60		23a. Part 1. Enter the disease, or complic	M005				ing R				ton,		20019 Approximate	
	anwenness.		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	the death. Do no	enter the mod	ie or dyn ş	g, 30 011 a3 0	ardiac or re-	opiratory a	1001,			Interval Between	
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	Examiner			E 79772	Stage Re		0980								
й.	WITTE,	iner	Sequentially list conditions, b. If any moding to immediate cause. Enter Underlying		consequence of								0		
	cuted nd transit	Examiner	Cause (Disease or injury that initiated events	Dyspl				_					\perp		
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200	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical	d.												
89	certific nding use as	W/u	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome o							23	3d. Date of	deliver	y	
Вох	eath o	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at		3 ☐ Ectopic 5 ☐ Other (s		:y 				Month		Day Year	
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Records,	law re has be e 2 st	Completed								24a. Was			to com	sy findings availab apletion of cause of	
Be	i: The		OF Miles and of second to made a				20 50			1 Yes	2 No			2 No	
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<u></u>	g Phy er this eral d	e: To	27. Manner of Death	28a. Date of injury (Month, Day,	y 28b. Ti		28c. Injury work				how injury		oechy)		_
OU	ending sath. er: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation	(Workin, Day,	rear/	ury M	1 \square	Yes 2 🗆 I	No						
Division of Vital	r Atter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farr . (Specify)	n, street, factor	y, office		28f.	Location (Number or	Rural F	Route Number,	
۵	oital o		29a. Certifier 1 X Certifying Physic	To the best of a	nu knaudadaa d	asth acquired	at the time	data and i	nlana and s	luo to tho	naueo(e) and	d mannar a	e etato	-	
	Hosp 24 ho Fune etely	ledical	(Check 2 Medical Examine	r: On the basis of ex	amination and/or	investigation, in	my opinio	on, death occ	curred at the	time, date	and place, a	and due to t	he caus	se(s) and manner s	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. Within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	a actioner. To the	. Door of thy Know		c. License		- and place,	2.0 000 10		signed (Mo			
	6		► lli	1 -			D	65729			Ju1	y 5,	201	2	
	19		30. Name and address of person who con												
			Farzad Malekanian			n Road	Sil	ver S	pring	, Md.	209	10			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 23 ^{Day}012 WILLIAM NORMAN LOWERY 1:31 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** TALBOT GENESIS HEALTHCARE-THE PINES EASTON Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral Country) MARYLAND Months JUNE 14, Year 1923 1 X M 2 □ F Days Hours Min. 89 264-22-8725 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT #12 ALBION COURT, EASTON 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 any injury or other traumatic event, the Medical Examiner must be 1 gines. Funeral **#12 ALBION COURT** 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify. WHITE Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MECHANIC ELEVATOR COMPANY Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN LECATES LOWERY DELLA CUMMINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN R. LOWERY, SON 8518 MILES COURT, EASTON, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/26/2012 STEVENSVILLE, MD CHESAPEAKE CREMATION 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 216 P.A. 21601 MERCERON CHA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused place in the cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final Spiractor Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death detached the g 🗌 Unknown 9 Unknown P.O. is been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an aw page 2: autopsy To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 200 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Daul, CKIN TLS STVA ame and address of person who completed cause of death (Item 23a) (Type, Print) Dutchman's CANE Eaton MD 1601 RND 610

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 2 7 2012

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or me

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katherine Lavada Lake Medical Facility Name (if pot institution, give street and number, Location of Death **Examiner** PARTON 500 Kom If Unde Year If Under 24 Hrs Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Jan. 18, 1934 North Carolina 214-32-5046 **Director** 78 1 □ M 2 🗓 F 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State should be filed within 72 hours after death with the Maryland Funeral Director ms 23a or 28a-f s must be notified Delmar 1 X Yes 2 No Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 19940 500 Jewell Street or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes Yes, Give White 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 XWidowed 4 ☐ Divorced Year or Dates ed other than "natur event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Baltimore, Maryland 21215-(Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Poultry Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Nora Mae Randolph Roy Leroy Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11522 East Snake Road, Delmar, Delaware 19940 Vivian Willey/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Berlin, Maryland 7/9/2012 4 Donation 5 Other (Specify) Sunset Memorial Park Signature of Juneral Service Li Zeller Funeral Home, P. 0. 1212 Old Ocean City Road, Box 3171 Salisbury, MD 21802 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only e on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-trait that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 L No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred V Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed, (Month, Day, Year) 0 completed cause of death (Item 23a) (Type, Print) TERN SHOLE DE, 32. Registrar's State Registrar

		1	State of Mary	-	rtment of H tificate of D			iene _{eg. No.} 2 (012 23613
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Deatl	n	3. Time of Death
	Physicia Medic		BETTY JEAN LANAHAN				JÜLŸ		012 8:10 A M
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or STEVENSV	Location of Death		4c. County	of Death ANNE * S
-/	Funeral		314 STAFFORD ROAD 5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	Birthplace (State or Foreign
	Director		219-34-9095 1 □ M 2 🕮 76	Yrs.	Months Days	Hours Min.	(Month, Day, 01/21/1		Country) MARYLAND
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Loc	ation				10d. Inside City Limits
	Maryla 18a-f s tified	Director	MD QUEEN ANNE'S	STEVENS	VILLE				1 ☐ Yes 2X No
	h the h la or 2 be no		10e. Street and Number		10f. Zip Code	·-		•	What Country? STATES
	ath wit	Funeral	314 STAFFORD ROAD 11. Marital Status 12. Was Decedent Ever in	n U.S. 13. V	21666 Vas Decedent of His	spanic Origin? (Spe			ce - American Indian,
ထွ	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	1f	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Blac Specify	ck, White, etc. :: WHITE
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212	withir ygiene her the		12	Н	IOMEMAKER			OWN H	
Maryland 21215-0036	ould be filed wi d Mental Hygie marked other matic event, th	To Be	17. Father's Name (First, Middle, Last) GEORGE MARVIN BARNES			18. Mother's Name GLADYS M			e)
aryl	1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura	il Route Number,	City or Town, S	State, Zip Code)
	and 2 st Health a tem 27 is		TIM LANAHAN / SON			ROAD, STE	VENSVIL		
Baltimore,	- 0		1 X Burial 2 Cremation 3 Removal from State		natory or other plac	e)	Date		- City or Town, State
<u>=</u>	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licensee		T CEMETER		-		GTON, DC
Ba	permit. Departr Imports any inji	. !	Y W M. A	FF 10	ELLOWS, H 06 SHAMRO	ELFENBEIN CK ROAD.	I & NEWN. CHESTER	AM FUNE MD 21	ERAL HOME, P.A.
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	Medical Examiner		resulting in death) Due to (or as a cor	isequence of):	N ALL	LIBASE			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		7.7	7011-0			
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	ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a con	isequence oi).					
3760	ficate I g phys as the	Medic	d						
P.O. Box 687	death certificate be executed ne attending physician and ed for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant at time.	Fetal death 3		су			ate of delivery onth Day Year
Bo	the at	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	e of death 5 L	Other (specify)				
P.0	es that the dea igned by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to		tribute to the cause of death?
ds,	been sign	ted k					1 🗆 Y		3 Probably 4 Unknown
COL	has be ge 2 sh	Completed					24a. Was a autop perfor	sy	Were autopsy findings available prior to completion of cause of death?
l Re	n: The ficate I		25. Was case referred to medical		26 PI	lace of Death (Chec	1 Tes		1 Yes 2 No
Vita	ysicial s certi directo	To Be	examiner? Hospital:	2 ER/Outpatier	Oth		ome 5 🗹 Resid	ence 6 🗆 Oth	her (Specify)
of	ng Ph fter thi nneral		27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day, Ye	ar) 28b. Time of injury	work	k?	28d. Describe he	ow injury occur	rred
Division of Vital Records,	death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	At home, farm, str		Yes 2 No	28f. Location (S	treet and Numb	ber or Rural Route Number,
<u>X</u>	al or A s after I Direct		4 Homicide determined building, etc. (S)	pecify)	,,,		City or Town		
_	Hospita 4 hours Funera ely fille	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of exam	ination and/or inves	tigation, in my opini	on, death occurred a	it the time, date ai	nd place, and di	ue to the cause(s) and manner state
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Me	only one) 3 Certifying Nurse Practitioner: To the be	st of my knowledge	, death occurred at 29c. Licens	the time, date and pl	ace, and due to the	ne cause(s) and	manner as stated. ed (Month, Day, Year)
	./1		1		063	5747		7/9	1/12
	INS		30. Name and address of person who completed cause of death	(Item 23a) (Type, I	D 1 10	Rosp, Ce		1.	21/.2
) ·	10	JEFFRY L. UILERY, M. 2. 31. Date filed (Month, Pay, Year) 32. Red strar's :			LON, Le	MIE VIN	= , my	21617
	Sta Registr		JUL = v 2012	Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 2012 JOHN WILMER LEGG 11:12 \mathbf{A}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPICE OF QUEEN ANNE'S INC. CENTREVILLE OUEEN ANNE'S 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 214-12-1923 1 XM 2 🗆 F 89 MARYLAND JAN.23,1923 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am jointy or other traumatic event, the Medical Examiner minimals. 10a. State 10c. City, Town or Location 10d. Inside City Limits by Funeral Director QUEEN ANNE'S CHURCH HILL 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 THE POND WAY 21623 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 🗌 Widowed 4 🗆 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) FARMER **FARMING** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OLIVER LEGG NATALINE HUNTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N.RUTH LEGG/WIFE 122 THE POND WAY, CHURCH HILL, MD 21623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State l 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State JULY 11, CHESTER, MARYLAND KINGSLEY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Puneral Service Lice Se FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one gause on each line. Onset and Death Immediate Cause (Final Physician/ houman disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner If any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Year ☐ Pregnant at time of death ☐ Unknown Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) HOSPICE CENTER Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 1 Natural 28a. Date of injury (Month, Day, Year) I Director: After the 28b. Time of 28d. Describe how injury occurred 5 Pending Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JUL - 9 2012

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20001

Registrar's Signature

40067888

21617

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. VERBAL G929 7/24/12 TRT State of Maryland / Department of Health and Mental Hygiene AMEND #26, PER VERBAL for State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 07:05 AM George Elwood Lashley 2012 Medical 4a, Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Wartards bura TOVI Washing nock If Under If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Se 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 Year Days Hours Country) 1 🕅 M 2 □ F Months Min 07/12/9/14/92/ 218-24-9408 84 Yrs MD Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 1 Yes 2 No Hancock MD Washington 10e Street and Number 10f. Zip Code 5 10g, Citizen of What Country? 23a Funeral USA 21750 216 Creek Road items death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Armed Forces? Black White etc. OF 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1945–46 Specify "natural", 3 XWidowed 4 ☐ Divorced White Completed other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) within Elementary/Seconday (0-12) College (1-4 or 5+) Game Manager Hunting Club 8 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be file alth and Mental H 27 is marked o ည Anna Catherine Thompson George Bernard Lashley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 14701 Warfordsburg Road Hancock, MD 21750 Joseph A, Lashley/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/13/2012 Mercersburg, PA Rehobeth Cemetery 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 MO0260 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Imphoma - Years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and-tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, law re uires 1 Yes 2 No 3 Probably 4 Unknown Completed should been: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy Hospital or Attending Physician: The this certificate Yes 2 25. Was case referred to medical Division of Vital director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home SON'S RESIDENCE Hospital 6 Other (Sper ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral price of the funeral part of t injury 1 Matural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifie Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗆 29b. Signature and title of cert 29d. Date signed (Month. Dav. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 Thern 31. Date filed (Month State Registrar

			For State Registrar	State of Marylan		artment rtificate			Mental H	ygiene Rag. No.	201	2 23	616
			Decedent's Name (First, Middle, Last)						2. Date of [Death		3. Time of	Death
н	Physicia		Clarceena Lorrai	ne MARTIN					July	11, Day	012 Year	11:19	p.M
3	/Medic		4a. Facility Name (If not institution, give			4b. City, T	own, or Lo	cation of Dea			County of Dea		-
05%	Examin	er	Golden Living			Has	gerst	own			Washir	ngton	
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1	Year I	f Under 24 Hr Hours Mir		Birth Day, Year)	9. Bi	rthplace (State o	or Foreign
	Director		220-64-6512	M 2⊠F 58	Yrs.	Months	Days	Hours	June	10, 1	.954 Mä	aryland	
	P .		Usual Residence of Decedent	100 6	ty, Town or Lo							10d. Inside C	ity Limits
	urylar show	_	10a. State 10b. County										2 □ No
	Be-f	cto	Maryland Washin	gton	наде	rstown				10- 6	izen ol What C		
	vith th	Directo	10e. Street and Number 11 West Baltimor	o Ctroot		10f. Zip (21740			10g. Cit	USA	ountry:	
	within 72 hours after deeth with the Maryland ene. Then "natural", or items 23e or 28e-f ehow he Medical Examinar must be collified at	Funeral		12. Was Decedent Ever in U	Q 13				Specify Yes or	No-	14. Race - Arr	erican Indian.	
	er de	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No		If Yes, specif	fy Cuban,	Mexican, Pue	Specify Yes or erto Rican, etc.)		Black, Wh		
36	irs aft	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2	⊠ No	Specify:			Specify:	white	
2-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual	Occupati	on	action	16b. K	ind of Busines	s/Industry	
7	nin 7.	ple	(Specify only highest grad	e completed) College (1-4or 5+)	lite.	DO NOT use	e retired)	ing most of w	UIKIIIY				
2121	d will giene	Completed	12	0	wa	itress					staurai	ıt	
덛	al Hy al Hy oth vent	Be	17. Father's Name (First, Middle, Last)				1		ame (First, Mide	dle, Maider	Sumame)		
<u>ā</u>	Ment Ment arked	2	Clarence Snyder						a Stone				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, in a Medical Examinar must be invitined at another.		19a. Informant's Name/Relationship (7) Eva Wishard - sis			-			Rural Route Nur agersto				
e)	l and lealth im 27 iher t		20a. Method of Disposition		Place of Dispo			Ive, ii	Date	-	ocation - City		
20	if its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre gersto	matory or oti	her place)	.rsz 7	/13/12			n, Maryl	land
Baltimore,	it. Part rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		0			1	INNICH				Laria
Ba	Depa Impo any i		1/1 -0-01	Perelin								ryland 2	21740
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	Dhusisian		shock, or heart lailure. List only o Immediate Cause (Final		10 0.		DOAR	10.11				Onset and	
d	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	uence of):	my c	JV VIC					1014	62(750
	Examiner			h									
		Je.	if any, leading to immediate	Due to (or as a conse	quence ol):					_			
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Ö,	ate be executed hysicien and the burial-transit	Ä	resulling in death) Last	Due to (or as a conse	quence of):								
8760,	physics the b	lical	•	d									
9 ×	death certifica e ettending ph id for use as ti	/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancv						23d. Date of d	lelivery	
Вох	etten for us	lan	in the past 12 months?	1 Live birth 2 Fet	al death 3	☐Ectopic pre☐ Other (spe					Month	Day	Year
P.0.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,,						
	law requires that the de as been signed by the e 2 should be detached f	Y P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	underlying ca	ause giver	in Part I.	23e. D	id tobacco	use conInbute	lo the cause of	death?
Records,	ulres n sign	d by							•	Yes 2	2 □ No 3 □	Probably 4]Unknown
00	w require s been sig should b	ete							24a. W		24b. Were	autopsy lindings	s available
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of Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of D	Death (Check or		-		
\geq	S S P	To B	examiner?	Hospital: 1 ☐ Inpalient 2	☐ ER/Outpatie	ent 3 DO	Other	4 Qursing	Home 5□P	lesidence	6 ☐Other (S	pecify)	
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Ö	Attending r death. ector: After by the fune	atle	2 Accident investigation			М	1 🗆 Y	es 2 No					
Division	r Att ter de irect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s sify)	treet, factory	, office			n (Street a Town, Sta		Rural Route Nu	mber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		20a Cadillar 41 Casifita Di	ysician: To the best of my kr	owlodes de-	ith occurred	at the time	data and cl	ace and due to	the cause/	s) and manner	as stated	
	Hos 24 ho Fun	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 2	inar: On the basis of examir and manner stated.	nation and/or i	nvestigation,	, in my opi	nion, death o	courred at the tir	ne, date ar	nd place, and o	lue to the cause	(s)
	within to the comple	Me	29b. Signature and title of certifier	2.4		290	. License	number			4	onth, Day, Year)	
	- ≤ + ō		1 Mania	v gonal	-		D23	36.5		-	7/12/	12	
			30. Name and address of person who	completed cause of death (Ite	am 23a) (Type	e, Print)							
5	DW+1		I MANZARS	SHAPIS	68 mi	ill &	tree	1-HO	Grito	DAME.	MD 2	1740	
		ate	31. Date filed (Month, Day, Year)	32. Régistrar's Sign	nature	had	1		0				
	Regist	rar		THE PERSON OF TH	total . A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07/07/2012 Physician/ 10:08 pm LILLIAN YVONNE MYERS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney 18301 Georgia Avenue, Apt. 118 Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-24-2877 **Director** 1 □ M 2√□ F MD 90 5/22/1922 Usual Residence of Decede ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 XNo Olnev MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral with USA 20832 18301 Georgia Avenue, Apt. 118 than "natural", or items he Medical Examiner mu within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Custodian—Vitro Labs Maintenance is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental ျ Margaret Virginia Dorsey Wintleid S. Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 18301 Georgia Avenue, #118, Olney, MD 20832 Darnell Myers/son item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ò injury (4 Domation 5 Other (Specify) 7/23/2012 |Cookesville, MD Cemeterv of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home any 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Senile Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical as the bur Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{X} \) No Dav Pregnant at time of death Linknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page Yes 2 XNo 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2**X** No 1 Tes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1**₹** Natural (Month, Day, Year) injury work? 1 Yes 2 No 5 Pending after death. Accident Investigation the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, by 4 Homicide determined filled in I within 24 hours at
To the Funeral Di
Completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/9/2012 D37142

Registrar

DHMH 17 Rev 06-2011

State

G.Coleman, M.D.
31. Date filed (Month, Day, Year)

M.D, 1355 Piccard Drive, Rockville, MD

Registrar's Sign

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

1 0 2012

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sudarshan Siva, M.D., 8600 old Georgetown Road, Bethesda, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MORAN Month 07 Physician/ 706EbH 0955hv5M 2012 Medical 4a. Facility Name (if not institution, give street and number)
Medical Century Examiner Olney, MP Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 234-32-4512 89 Director 1 **X** M 2 □ F Aug. 1 1922 West Virginia ms 23a or 28a-f show must be notified at 10c. City, Town or Location 0a. State 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 15111 Glade Drive, Apt. 3A 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WW☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: WII Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working 2 should be filed within 72 hand Mental Hygiene. 77 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the County Public School <u>Guidance Counselor/Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hezekiah L. traumatic Moran Hattie L. Musarove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s t of Health a if item 27 i John Moran / Son 7312 Rosewood Manor Lane, Laytonsville, MD 20882 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of Important: If it any injury or c cemetery, crematory or other place) 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 7/11/12 Silver Spring, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Barber Funeral Home Francis Anthon Barber P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ neumon disease or condition resulting in death) Medical Due to (or as a consequence of 2-3 days Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ó in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes 2 L ☐ Unknown Yes 2 No the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🏿 Yoo 3 🗎 Probably 4 🗎 Unknown Division of Vital Records, Completed peen 0-1 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy perform hours after death.

uneral Director: After this certificate 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be filled in by the Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0071

10x

State Registrar Farhan Imran,

31. Date filed (Month

DHMH 17 Rev 06-2011

3800 Reservoir Rd

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

mran

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Formour

Washington, D.C.

N.W.

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12-05013 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Richard Allen MarQuardt 1- For State Certificate of Death I. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Time of Death Month Day July 4, 2012 Examiner Richard Allen Marquardt 1658 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Decatur Park Worcester 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Months Days Hours Director 074-24-3293 1XM 2 F 9/2/1930 NY Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 X No Worcester Belin Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. ant. If teen 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 211 William St., Apt. 21811 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funer Armed Forces? White, etc. 1 Never Married 2 Married 1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: white 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) et Baltimore, MD 21215-0036 Compl U.S. Air Force U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louisa unknown Charles Marquardt ္ 19a, Informant's Name/Relationship (Type, Pnnt) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel Marshall Farr 206, Ocean City, MD Atlantic Ave. Apt. 20a. Method of Disposition Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/6/2012 First State Crem. Millsboro, DE Donation 5 Other Specify 22. Name and Address of Facility Burbage Funeral William Berlin St. 21811 Physician /Medical Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each lip Between Onset and Contact Gunshot Wound of Head Immediate Cause (Final disease a Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause, Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last The law requires that the death certificate be executed d and Physician/Medical signed by the attending physician I be detached for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown gΓ Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 X Unknown Completed certificate has been ector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? X Yes 2 No 1 X Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26.Place of Death (Check only one examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 X Other. Scene ER/Outpatient 3 DOA After this 1 X Yes 2 No Manner of Death 28c, Injury at Work 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 1 Natural Subject shot self 5 Pending 1 Yes 2 X No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide 6 Could not be or Town, State) Berlin, MD 21811 determined 4 | Homicide (Specify) Park/Recreation Area Dacator Park Route 113 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCMF O.C.M.E. July 5, 2012 Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State

Registra

31. Date filed (Month, Day,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MESSINEO OIDAM 09 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign **Funeral** Country) **Director** Capital Heights Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 ☐ No 10e. Street and Number ō 10g. Citizen of What Country? Funeral items 23a 20639 Was Deceue. Armed Forces? Ves 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. ò 9 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify "natural", Whit 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n tenance other traumatic event, Be irst, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, and Mental F မ permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or care. 18351ne0 19a. Informant's Name/Relationship (Type, Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Suitland, MD 4 Donation 5 Other (Specify) 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Due to (or as a consequence of) Cancey disease or condition resulting in death) Medical > 1 year Examiner olan cano Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examir Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 17N 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COPD autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 2 No Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier NIMIT SHAM, MD Nohall 138r

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shitt

31. Date filed (Month, Day,

D72608

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ 9:37 AM 2012 Carolyn Marshall Medical Name (if not institution, give str County of Death **Examiner** 01 8. Date of Birth **Funeral** 1 🗆 M 2 Min (Month, Day, Year) Country) Director 578-74-0053 55 12-12-1956 Washington, DC 28a-f show 10d. Inside City Limits 10a. State 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location **Funeral Director** 1X Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21061 United States 127 Allen Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give AMOLY Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: $^{\text{Specify:}} \ \textbf{Black}$ Completed 3 Widowed 4 M Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Daycare Teacher Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မှ Jeanette Williams #CS HALL John Allgood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 127 Allen Road Glen Burnie, MD 21061 April Allgood/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Page 1 ment of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 07-07-2012 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Cemetery 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of uneral Service β401 Bladensburg Rd. Brentwood MD 20722 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1 Enter the disea shock, or heart failure. List only one Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year page 2 should be detached 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 2 No 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: ပ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗔 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Phint) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06/ 2012 9:13A 26 Sheila Mann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 545 Cynwood Drive #207 Easton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) U • K • Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday **Funeral** Hours 1 □ M 2 🕅 F Months Days Min. 214-58-3150 94 Director 12/20/1917 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Director Talbot Easton 1 X Yes 2 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 545 Cynwood Drive #207 21601 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 -0-Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Scarborough Edith Frederick Haskel] 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3433N. Venice St. Arlington, VA. 22207 J.David Mann / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Delmarva 6/30/12 Delmar, DE. Crem. 21. Signature of Funeral Service Licensee

Ostyh M. Ostrowsk! C.F.S.P. Hurried Address Ostrowski Funeral Home P.A. .0 518 St. Michaels, Box 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 7/2009

TLS

State Registrar Idlewild Ave., Easton,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanchez

For Amend 26 per physiate of Maryland / Department of Health and Mental Hygiene State Registrar DOR, 7/11/12, LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Morris 06 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Queenstown QA Queen Anne's Emergency If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Director 1 🗆 M 2 💢 F Sept. 6, Maryl items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 № Yes 2 □ No rasonvil 10e. Street and Numb 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ondary (0-12) College (1-4 or 5+) NOY Be 17. Father's Name (First, Middle, Last) ျ Mary Robinson arm 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Charles 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory 1 Burial 2 Cremation 3 Removal from State orasonville, MD. 4 \square Donation 5 \square Other (Specify) Signature of Funeral Service Licensee 22. Name and Address Facility.
Henry Funeral
Sio washingt HOMP, 23a. Fart 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi 16 N that initiated events resulting in death) Last as a consequence of physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ be detached for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 1 Yes 2 X No Yes 2 No the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospita 2 No မ 1 🗌 Yes 3 🕱 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **X** Natural 5 Pending Accident M 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature alised , M. 1) 000 27 055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Year

DHMH 17 Rev 06-2011

State Registrar Wilkerson

Joel H

Center Road, Grasonville, MD

204 Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 July Ray Eugene Moore 1:20 Medical a 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number If Unde If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) 218-16-6756 87 **Director** 1 X M 2 🗆 F Yrs April 15,1925 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5616 Cassons Neck Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, med Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 👿 Yes 2 🗌 No If Yes, Give WWII Year or Dates. white 1 Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other tha plant worker chemical Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hv.
Important; if item 27 is markany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orville Moore Leota Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray E. Moore Jr. son 5616 Cassons Neck Road, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🛣 Cremation 3 🗌 Removal from State Crematory of Delmarva 7/7/12 Delmar, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final Physician cementa disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of in that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No g Unknown a 🗌 Haknowa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by athlerosclerotic Cardiovascular 1 Yes 2 □ No 3 □ Probably 4 □ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \sum Yes 2 \sum No Natural injury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completely filled in by determined City or Town, State) Medical

To the within 2

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ohn son

32. Registrar's Sign

Registrar DHMH 17 Rev 06-2011 100 Bramble

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Cambridge, ND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month atherine Sampson 2012 5014 40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice 16. Sex aston House Ta/607 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗷 F Months Days Hours Mir Maryland Director or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Easton 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a SA 2160 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 ₩Widowed 4 □ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OMeone else's home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Woodlands 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) tillsboro Maryland 22. Name and Address Facility Home, P.A. Henry Funeral Home, P.A. 21. Signature of Funeral Service Licensee Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Physician/ Varian disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordenying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 5 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2.4 No Jas certificate has irector, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1124/98

Registrar

State

DHMH 17 Rev 7/2009

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CKNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 0530 M Adeline Simpson Mock UL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CAMBRIDGE GENERAL ORCHES1 DOA CHESTER 8. Date of Birth May 6, 1915 5. Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Hours Min. 97 Mary land Director 222-03-6232 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3712 Willey Road 21643 USA permit, Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 1 Yes 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Ezekiel Simpson Elizabeth Fleckenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Mock/Son 3712 Willey Road, Hurlock, Maryland 21643 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Unity Washington Cem. 7/5/2012 Hurlock, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility eller Funeral Home, P. O. Box 207 Do Main Street, East New Market, MD 21631 Signature of Funeral Service L complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limitary Examiner Due to (or as a consequence of) sician and burial-transit Cause (Disease or lingur that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Niknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No Accident Suicide Investigation after death Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 17 D69234 07 MD 03 2012

DHMH 17 Rev 7/2009

State

Registrar

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CAMBRIDGE

MD

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of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

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	-	For State Registrar		State of N	laryland		artment of H rtificate of		ı mental Hy	/giene Reg. No	0.0.1	2 2262
		Decedent's Name (First,	t, Middle, Lasi	t)					2. Date of De		291	3. Time of Death
Physicia /Medic		WILLIS	>		SLANT	>	T				8 12	1-500 M
Examin	er	4a. Facility Name (If not ins ートンていれ	-	.\	n EGAP <i>EN</i>	ur	4b. City, Town, o		eath	١.	. County of Deal	NUNNEL
Funeral		5. Social Security Number	r 6. Se		ge (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D	rth a <i>y, Year,</i>	9. Bir	thplace (State or Foreign ountry)
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ryland		10a. State 10b. C	County		10c. City,	Town or Lo	cation				·	10d. Inside City Limits 1 □Yes 2 No
the Ma 28a-f	Director	MD QU 10e. Street and Number	UEEN AN	INE'S	ST	EVENS	VILLE 10f. Zip Code			10a C	itizen of What Co	
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er deat Items 2	Funeral	11. Marital Status		12. Was Deceder Armed Forces	3?	13.	Was Decedent of H		(Specify Yes or N lerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
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within iene. than	dmo	Elementary/Secondary ((0-12)	College (1-4o	r 5+)		DO NOT use retire UCK DRIVE			TR	RUCKING	
e filed al Hyg Jother went,	Be C	17. Father's Name (First, M							lame (First, Middle		n Surname)	
nould b	70	FREDERICE							V. PARK		T	7-0-4-)
nd 2 st alth and 27 Is n rtraur		19a. Informant's Name/Re APRIL BALECE					ng Address <i>(Street</i> FIMBER LA					Zip Code)
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examples must be notified at once.		20a. Method of Disposition 1X Burial 2 □ Crem	on		20b. Pla		osition (Name of matory or other pla		Date		Location - City or	Town, State
t. Page rtment rtant: I		4 □ Donation 5 □ O	Other (Specify	')		ENSVI	LLE CEME	TERY 07,		1		•
permi Depar Impor any Ir		21. Signature of Funeral 3	Service Licens	See /	2		ELLOWS, F BOS SHAMRO	ELFENBE	IN & NEW	NAM D M	FUNERAL	HOME, P.A.
		23a. Part 1. Enter the dise shock, or heart failur	ease, or comp	olications that daus	ed the death.						ID 21019	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_	a. RESPI	MOLLE	1	NSU PET	CIENCY				Onset and Death
/Medical Examiner					as a conseque	,	LATERA		CLEMOSI	c		
pd iti	iner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	ns, ate		as a conseque		07 1012		CLUIW 31			
executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c Due to (or a	as a conseque	nce of):						
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ertifice ding ph	Med	IF FEMALE:		23c. If yes, outcon	no of prognan	21.6						
death of	Physician/Medica	23b. Was decedent pregn in the past 12 months 1 ☐ Yes 2 ☐ No	mam	1 ☐ Live birth 4 ☐ Pregnan	n 2 ☐ Fetal of t at time of dea	leath 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date of de Month	Day Year
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ires sign	þ	Part II. Other significant of		Ontributing to death	n but n ot result	ing in the u	inderlying cause gi	ven in Part I.			use contribute t	o the cause of death? Probably 4 Unknown
e faw requ has been e 2 should	Completed	STATUS PO	057	ASPINAT	100	PNE	UMONIA		24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
i lcian : The certificate h ector, page	Com	STATUS PO	057	MECENT	PULM	LOWA	1 Gr	1BOL1	per 1 □Yes	formed?	death?	· _
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Attending Physician: r death. ector: After this certific. by the funeral director, p	on: To	27. Manper of Death	Pending	28a. Date of I		28b. Time of Injury	of 28c. Inju	ıry at rk?	28d. Describe			cony
ttendi death. stor: A / the fu	icati	2 Accident	investigation Could not be	,	Injury - At hom	ne farm st	M 1 E	Yes 2 □No	28f. Location	(Street :	and Number or F	Rural Route Number,
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier 1 C C (Check only one)	Certifying Ph Medical Exan	ysician: To the be niner: On the basi and manner	s of examination	ledge, dea on and/or i	th occurred at the nvestigation, in my	ime, date and p opinion, death o	lace, and due to the control occurred at the time	ne cause e, date a	(s) and manner and place, and du	as stated. ue to the cause(s)
To the within To the compl	Me	29b. Signature and title of	of certifier	1	20	. [\	se number		29d. D	Date signed (Mon	nth, Day, Year)
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Sta		31. Date filed (Month, Day	1 () 20°	2 32 Regi	strar's Signatu	. 4		1	, , , ,	,		
Registr	ar		- 0 - 20	-	,	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Laurel Prince George Laure Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs Hours Min. 215-63-1690 37 6 M978 97 97 5 1 🛂 M 2 🗆 F Cameroon Director or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ould be filed within 72 hours after death with the old Mental Hyglene.

Marked other than "natural", or items 23a on marked other than "naturals", or items be matic event, the Medical Examiner must be. Funeral 526 Southampton Drive 20903 Cameroon 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【★No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file 2 Fuaveke James Nyoh Bunah Helen permit. Page 1 and 2 should Department of Health and M. Important: If item 27 is mart any injury or other. 19a. Informant's Name/Relationship (Type, Print) Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209127401 New Hampshire Ave. Takoma Park, Md Lawrence Tiove Sambawei 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Babessi-Ngop, Date 1 X Burial 2 Cremation 3 X Remy val from State 7/28/2012 Family Cemetery 4 Donation 5 Donation 5 Other (Specify) Cameroon PHYTTIPADESKINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Physician/ Kenal Disease disease or condition Medical resulting in death) Examiner Immune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of The law requires that the death certificate be executed the attending physician and shed for use as the bungarians that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 □ No ed by the a 9 Unknown signed b Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pheumonia Division of Vital Records. been sig 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performe certificate r: After this certifica the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' hours after death, 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

completely filled in by the f Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) **JUL 10 2012** Registrar

Abdul Munim, MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Laurel

Van Dusen

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June 28, 2012

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 7, 2012 9:08 A M Karen Jean NURICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda 6310 Poe Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 62 **Director** 115-42-2236 1 □ M 2 🕅 F Yrs June 4, 1950 New York Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. 10b. County Director 1 Yes 2 No Bethesda Maryland Montgomery 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral United States 20817 6310 Poe Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event "to once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Foreign Service Office Public House Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Selma Buchdahl Seymour Nurick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6310 Poe Road, Bethesda, MD 20817 19a. Informant's Name/Relationship (Type, Print) Eduardo Sainz, Husband 20a. Method of Disposition 07/10/12 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garden of Remembrance Memorial Park 1) Burial 2 Cremation 3 Removal from State Clarksburg, MD Donation 5 Other (Specify) 21. Signature of Fune all S Torchinskysshebrew Funeral Home 20012 254 Carroll St., NW. Washington, DC for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Pttytician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attenting Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Dijector After this certificate has been sinned by the otherwise and the continued of the contribution of the continued of the contribution of th Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 20 July 7, 2012 DC 11864 udence 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prudence P. Kline, M.D., 2021 K Street, NW, Suite 512, Washington, DC 20006

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 4:37 AM Charles R. Noble 2106 06 CIT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wi comi ca Coastal Hospica at the Lake Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 73 215-38-0702 Director 1 MM 2 □ F 01/06/1939 Maryland Usual Residence of Decedent permit. Paga 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Haaith and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaininer must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 No Princess Anne Somerset 10g. Citizen of What Country?
United States 10f. Zip Code 10e. Street and Number 21853 Funeral 27840 Oriole Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. 3 ₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Heavy Equipment Elementary/Secondary (0-12) College (1-4 or 5+) Service Manager Be 18. Mother's Name (First, Middle, Maiden Surpame) Charlotte Hickman Noble 17. Father's Name (First, Middle, Last) ပ Charles Noble 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number of Bural Boute Number City or Topya, State, Zip 859 Wade Noble 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 07/09/2012 Salisbury, MD. 4 Donation 5 Other (Specify) Salisbury Crematory 22. Name and Address of Facility Hinman Funeral Rome 21. Signature of Funeral Service Licensee M00295 21853 11673 Somerset Ave., Princess Anne, MD. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Par speck, or heart ion-immediate Cause (Final disse or condition in death) CHRONIC Priysiciani Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be axacutad within 24 hours after death.

To the Funeral Director: After this certificate has baen signed by the attending physician and complataly filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Z No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) LOSPICE 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 2410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 WARCS 31. Date filed (Month, Day, Year) State JUL 10 Registrar

DHMH 17 Rev 06-2011

Noble

			For State of Mar	ryland / Depa			lental Hyg	giene	0.1.0	00000
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	Death		Reg. No.	0/2	63536
	Physicia						2. Date of Dea	7/2012	Year	3. Time of Death 7:15 A M
	Medic Examin		MONICA MATEJA NORRIS 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	00/2	4c. County	of Death	
			TALBOT HOSPICE HOUSE		EASTON			TAL	вот	
	Funeral		E60 01 0110	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		g. Birthp Count	lace (State or Foreign
	Director		Usual Residence of Decedent	87 Yrs.			12/19/1	924	ALABA	MA
	f shov	tor	10a. State 10b. County 1	IOc. City, Town or Loc	ation				10	Od. Inside City Limits
	Many 28a-	Director	FL ESCAMBIA	PENSACOL						1X Yes 2 □ No
	ith the		10e. Street and Number 2007 EAST GADSDEN #103		10f. Zip Code 32501			10g. Citizen of V USA	Vhat Coun	try?
	eath w	Funeral	11. Marital Status 12. Was Decedent Eve		/as Decedent of His	spanic Origin? (Spe			e - America	an Indian,
36	ifter d ", or i amine	by	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	0	Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)	Specify:	k, White, e	
21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 Widowed 4 □ Divorced Year or Dates.		ent's Usual Occupa				170	
215	n 72 h an "n Medi	ldm	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k		uring most of work	ing	16b. Kind of Bu	usiness/inc	ustry
7	I withi ygiene her th t, the		8 -0-	MAN	IAGER			RETAIL	SALE	S
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) ANDREW MATEJA			18. Mother's Name BERNICE		Maiden Surname	*)	
37	should be file and Mental 7 is marked c		19a. Informant's Name/Relationship (Type, Print)	19h Mailin	n Address (Street a	and Number or Rura		City or Town S	tate. Zio C	ode)
ž	d 2 sh alth a 27 is er trau		KENNETH P. HANNEGAN			R. EASTON		-	.u.o, <i>Lip</i> 0	000)
Baltimore,	e 1 and t of Heal If item? or other		20a. Method of Disposition 1 □ Burial 2 🔀 Cremation 3 □ Removal from State	20b. Place of Dispos		et on le	Date	20c. Location -	City or To	wn, State
<u>E</u>	permit. Page 1 Department of Important: If i any injury or o		4 ☐ Donation 5 ☐ Other (Specify)	CHESAPEAR CENTER	CKEMAI	06/28		STEVENS		
Ba	Depar Depar Impol any ir		21. Signature Full Service Learns			RISON ST				HOME, P.A.
			23a. Part 1. Enter the disease, or complications that caused the	e death. Do not ente						Approximate
	nysician/	10. 1	Immediate Cause (Final disease or condition	ntia						Interval Between Onset and Death
1	Medical Examiner		resulting in death) Due to (or as a c							
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a c	onsequence of):					-	
	uted Id ransit	Examiner	cause. Enter Underlying Underlying Cause (Disease of Injury that initiated events c.						- 4	
	ate be executed hysician and the burial-transit	al Ex	resulting in death) Last Due to (or as a c	consequence of):						
760	death certificate be executed the attending physician and ed for use as the burial-transi	edical	d					-1		
687	certifi nding use a:	M/u	IF FEMALE: 23c. If yes, outcome of					23d. Da	te of delive	ry
P.O. Box	requires that the death certifica been signed by the attending p should be detached for use as	Completed by Physician/Me	1 Yes 2 No 4 Pregnant at ti	Fetal death 3 Ime of death 5 Ime	Other (specify)	y 		Мо	nth	Day Year
o	at the d by th	Phy	g Unknown 9 Unknown Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause giv	en in Part I.	23e Did to	hacco use contr	ibute to the	e cause of death?
S, D	ires th signe id be d	d by	Atherosclerotic vasc	1	isease					ably 4 Tonknown
ord	v requ	olete	Severe aortic ste	nosis			24a. Was a		Nere autop	sy findings available
Sec	The lay ate has	om	Hypertension				autop: perfor 1 Yes	med?	orior to con death? I \(Yes \)	npletion of cause of
ta 	cian: ertifica ector,	Be (25. Was case referred to medical examiner?			ace of Death (Check				
<u> </u>	Physi this o	일	1 ☐ Yes 2 ☒ No ☐ 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	t 2 ER/Outpatient	28c. Injury	4 🖂 Nursing Ho		ence 6 124 Othe	er (Specify)	10spice House
0 00	nding ath. : After e fune	icate	1 Second Natural 5 Pending (Month, Day, You are Investigation (Month, Day, You are Investigation)		work'	Yes 2 No	28d. Describe ho	ow injury occurre	ea	
Division of Vital Records,	r Atter	Certificate:	3 Suicide 6 Could not be	- At home, farm, stre	et, factory, office		28f. Location (Si		er or Rural	Route Number,
á	pital o					Y)				
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner on the basis of examiner. 2 Medical Examiner: On the basis of examiner.	mination and/or investi	gation, in my opinio	n, death occurred at	the time, date ar	nd place, and due	e to the cau	se(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	ook or my who who ago,	29c. License	number	- 2	29d. Date signed	(Month, E	lay, Year)
	125		Nashmi Vardyanathan	(IV)	200	7749		06 - 2	28 -	2012
	12		30. Name and address of person who completed cause of deat LAKSHMI VAIDYANATKAN			JCT EG	STON	MD 2	160	Ī
	Stat	e	31. Date filed (Month, Day, Year) 22. Registrar's	Signature		- 3.) 61	, , , , , , ,		-00	1
	Registra	ar	JUN 2 9 2012 Sentra	A. par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Francis Clement Oster 30 5:10 a June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min NOV 23 Year) 933 1**™** M 2 □ F Mary land 215-34-8401 78 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar misst he matter and 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Westminster Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 225 Frock Drive Apt 110 21157 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. white 3 XWidowed 4 □ Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Computer Programmer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Oster Sr. Mary Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Kemper Avenue, Westminster, MD 21157 Francis H. Oster, son 20a. Method of Disposition 20b. Place of Disposition (Name of capell), Frematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 7/3/2012 Carroll Crematory Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 Physician/ 0 20 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death by the page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an en515 has autopsy death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. I Director; After t Certificate: injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 204 R049707 0 2012

State Registrar JACQUELLNE F 31. Date filed (Month, Day, Year)

3

6886 Poole Rd WESTMINSTER

and address of person who completed cause of death (Item 23a) (Type, Print) QUELINE P HEARN CRNP 688C Po

Registrar
DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margie Owen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ann Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 407/16/5248 **Director** 90 1 □ M 2 🗶 F 09/19/1921 28a-f show 10a. State with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Tes 2 No Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1611 Ritchie Highway 21012 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Hairdresser Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Lay Edna Pelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Yurek (nephew) 1161 Ritchie Hwy, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 7/5/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျ 2. No Other: 1 Inpatient 2 § ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending after death. Director Af 1 Tyes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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Veterans Howy Sucte

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Millersvill

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06 2012

			For State Registrar	State of Maryla		artment of F tificate of D		i Mentai Hy	giene Reg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last					2. Date of De	ath	1 Year	3. Time of Death
may.	Medic Examir	cal	John Aloysius 0'B 4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Dea	July sth	4c. County)1 ^{Ygar}	21:10 м
ز	LXaiiii	ici	Anne Arundel Medi			Annapol			Anne	Arund	.e1
	Funeral Director		5. Social Security Number 6. Set 577-14-7576 1 E	Y	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	y, Year)	9. Birthpl Counti	lace (State or Foreign ry)
			Usual Residence of Decedent	A M 2 □ F 87	Yrs.			07/20/	1924	Washi	ngton,D.C.
	ıryland I-f sho ied at	cto	10a. State 10b. County		City, Town or Lo		1.			10	Od. Inside City Limits
	he Ma or 28a e notif	Dire	Maryland Anne Ar 10e. Street and Number	undel		Anna 10f. Zip Code	polis		10g. Citizen of	What Count	1 Yes 2 X No
	s 23a sust be	Funeral Director	2900 Shipmaster W	ay, #107		21401			United		*
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ⚠Yes 2 ☐ No If Yes, Give Year or Dates. WWI		Vas Decedent of His Yes, specify Cubar		Specify Yes or No- rto Rican, etc.)		ce - America ck, White, et	
2-0	2 hour "natul adical	plete	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	ent's Usual Occupa	ation	orkina	16b. Kind of B	usiness/Indi	ustry
121	within 7; giene. ner than t, the Me	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	NOT use retired) rtender	aring most or we	Jiking	Dinin	ıα	
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ylar	should be file and Mental F is marked o raumatic eve	입	John A. O'Brien,				Maud M	arion Be	lk		
, Mar	and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationship (Typ. Rose L. O'Brien/W		19b. Mailin 2900	g Address (Street a Shipmast	nd Number or R er Way,	ural Route Numbe #107, Ai	r, City or Town, S nnapolis	State, Zip Co S , MD	21401
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or otl		20a. Method of Disposition 1	Removal from State	Place of Dispos cemetery, crem las Cres	atory or other place	07/	Date 05/2012	20c. Location - Edgewat	,	_{vn, State} lary1and
Ball	permit Depart Import any inj		21. Signatur Funer Seven Linnse	e		Name and Address					
	easting sec		23a. Cart . Enter the disease, or compl shock, or heart failure. List only one	cations that caused the de cause on each line.	ath. Do not ente	r the mode of dying	, such as cardia	c or respiratory arr	rest,		Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	s pive	tory	Fe	ilwe			Onset and Death
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	d d	edical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	1	_		E.			
	xecute al-tran	Exar	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		-I CULX	N_	1 BM	UNTO	N	
Ö	icate be executed physician and is the burial-transit	lical		I		_					
3876	irtificat ling ph		IF FEMALE:	20.16			_				
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)	1			te of deliver onth C	y Day Year
P.0	s that t gned by	by PI	Part II. Other significant conditions con		esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use conti	ribute to the	cause of death?
rds,	equire een si	eted	Preumoni	^				1 🗆 `	res 2 □ No	3 Proba	ably 4 Unknown
Division of Vital Records,	The law r	Completed	HYPOXA					24a. Was a autop perfor	rmed?		sy findings available apletion of cause of
ital	nysician: The nis certificate I director, pag	m	25. Was case referred to medical examiner?	ospital:		Othor	ce of Death (Che				
of <	ding Phy h. After this funeral d	te: To	27. Manner of Death	1 Nnpatient 2	28b. Time of	28c. Injury	4	Home 5 Resid			
on	eath. or; Aft	ficat	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	work? M 1 □ Y	∕es 2 □ No				
Divis	Hospital or Attending F 24 hours after death. Funeral Director: After etely filled in by the funer	al Certificate:	3 U Suicide 6 U Could not be determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (S City or Town	treet and Numbe n, State)	er or Rural R	Poute Number,
	To the Hospital or Attend Within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	(Check 2 L Medical Examine	cian: To the best of my kno er: On the basis of examinat Practitioner: To the best o	on and/or investi	gation, in my opinion	 death occurred 	at the time, date as	nd place, and due	e to the caus	e(s) and manner stated
	To the within 2 To the Comple		29b. Signature and title of certifier	V P		29c. License			29d. Date signed	d (Month, Da	ıy, Year)
	5x\		30. Name and address of person who con	mpleted cause of death (ite	m/23a) (Tivne Pr		2036		7/	4112	
	J W		EVA S	HER	SH	MD	445	Defo	MD	718	1401
	Stat Registra	_	31. Date filed (Month, Day, Year)	32/Registrar's Sign	ature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Eleanor Pavek J_{uly}^{MORIT} 1, 2012 4:55 p м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Emmitsburg Frederick St. Joseph's Ministries Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Min Year 92<u>0</u> 320-12-3218 91 July 6, Illinois Director Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Emmitsburg Frederick 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 USA 101 East Main St 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. Hygiene. other than "natural", or i 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ¥Widowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Civil Servant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Bartholomew Moczarny Regina Seliga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 101 E Main St, P.O. Box 419, Emmitsburg, MD 21727 1 and 2 s if Health a item 27 i Larry Pavek, son injury or other 20b. Place of Disposition (Name of cemania) Lemantory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State Carroll Crematory 7/2/2012 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Signature of Funeral Service Licenses 22. Name and Address of Facility any 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrink, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury accurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; Aft Investigation □ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie m 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

			For 1 _ State	State of Marylan		artment of I		Mental Hy	201	0 0000
			Registrar 1. Decedent's Name (First, Middle, L	ast)	Cei	uncate or i	Jean	2. Date of De	Reg. No.	<u>/ /303(</u>
	Physicia Medic	cal	Adela	Victoria	Pi	neda		July	5,2012 Year	3. Time of Death 5:35p _M
	Examin		4a. Facility Name (if not institution, ga Manor Care La	rgo		Lar			4c. County of Dea	deorge's
	Funeral Director		217-88-3333	Sex 7. Age (In yrs. In 1 M 2 XF	ast birthday) 87 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ly, Year) Co	thplace (State or Foreign untry) Salvador
	and show	ō	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
	Maryl 28a-f notified	Direct		e George's H	yatts					1 ☐ Yes 2 🔀 No
	s 23a o	Funeral Director	10e. Street and Number 4205 74th Ave	enue		10f. Zip Code 2 (784		10g. Citizen of What Co El Salva	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fur	11. Marital Status 1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates.	S. 13. \	Was Decedent of F f Yes, specify Cub I Yes 2 ☐ No	ispanic Origin? (S an, Mexican, Puer El Salv Specify:	pecify Yes or No- to Rican, etc.) adoran	Black, Whit	
21215-0036	within 72 hou giene. er than "nat the Medica	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done O NOT use retired) Homema	during most of wo	rking	16b. Kind of Business Own Hom	
Maryland	d be filed wental Hygarked otheral	To Be	17. Father's Name (First, Middle, Las Sebastian Gra			_	18. Mother's Na Aure	me <i>(First, Middle,</i> lia Pin	Maiden Sumame) 1eda	
	d 2 shoul alth and I 27 is ma		19a. Informant's Name/Relationship Martha Margar: Viuda de Agui	Type, Print) ita Pineda- lar/daughter					er, City or Town, State, Zi	Code)
Baltimore,	Page 1 and ent of Hea nt: If item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	20b. F	Place of Dispo	sition (Name of natory or other place Heaven		Date	20c. Location - City or	
Balti	permit. F Departm Importa any inju		21. Signature of Funeral Service Life		PŦ	Pamarapa Adore	SRIPALD:	I FUNEF	RAL SERVIC	E,P.A.
	Physician/		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that caused the deat one cause on each line. Cardiopu				or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequently pertently	atheros	clerot	ic card	lio Vascul	ar dis.	
	Led Led	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. ————————————————————————————————————						
0	e be executed ysician and e burial and	dical Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):					
68760	rtificate ing phys e as the		IF FEMALE:	d						
Box	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director After this certificate has been signed by the attending physician and Funeral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the buriaterals.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of of	al death 3	Ectopic pregnand Other (specify)	Э		23d. Date of de Month	livery Day Year
ds, P.O.	luires that t		Part II. Other significant conditions gangre	contributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.		obacco use contribute to Yes 2 ☐ No 3 ☐ P	
Records,	The law require cate has been s page 2 should	Completed by							psy prior to death?	topsy findings available completion of cause of
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Cth	ace of Death (Che	eck only one)		
of Vital	g Phys er this reral dir	te: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of	nt 3 □ DOA 28c. Injur	4 lat Nursing I y at		dence 6 Other (Spec	cify)
ion	Attending I er death. ector: After by the funer	Certificate:	1X Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	ion	injury		Yes 2 No			
Division	tal or At irs after d al Direct led in by		4 Homicide determine	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or Tou	Street and Number or Ru vn, State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 ☐ Medical Exa	nysician: To the best of my knowl miner: On the basis of examination urse Practioner: To the best of my	n and/or invest	tigation, in my opini	on, death occurred	at the time, date a	and place, and due to the	cause(s) and manner stated.
	with Som		29b. Signature and title of certifier			29c. Licens			29d. Date signed (Monte	
			30. Name and address of person wh			Print)				1
	Stat	te	31. Date filed (Month, Day, Year)	dad M.D. 132	8 Sou	thern A	ve #310	washi	ngton,D.C.	. 20032
	Registra		JUL 1 0 20	37. Registrar's Signat	1. 194					

DHMH 17 Rev 7/2009

			For State	State of M	Maryland / Dep			lental Hyg	jiene	010 0000
	_		Registrar 1. Decedent's Name (First, Middle	(act)	Ce	rtificate of l	Death	2. Date of Dea	Reg. No.	112 2363
	Physicia		Eunice Billing	. ,					7/2012	Year 3:10P M
	Medic Examin		4a. Facility Name (if not institution			4b. City, Town, o	r Location of Death		4c. County	of Death
med (4813 Drummond			Chevy C			Mont	gomery
	Funeral Director		5. Social Security Number 579-34-5497	6. Sex 7. A	age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	I LI M Z ES F	83 Yrs.			01/03/1	1929	Washington, DC
	yland f sho	ctor	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	r 28a notifi	Director	Maryland Montg	gomery	Chevy C	10f. Zip Code			10g. Citizen of V	1 X Yes 2 No
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	eral	4813 Drummond	Avenue		20815			Jnited S	•
	ltems	Funeral	11. Marital Status	12. Was Decedent Armed Forces			lispanic Origin? (Spe an, Mexican, Puerto			ce - American Indian,
36	after (II', or xamir	d by	1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2 2 If Yes, Give		1 ☐ Yes 2 🛣 No			Specify:	ck, White, etc.
9	hours natura lical E	lete	15. Decede	nt's Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of B	White
21215-0036	iin 72 ie. han "i	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4 or	(Give	e kind of work done DO NOT use retired)	during most of work	ing		,
7	d with Hygier ther t	Be C	17. Father's Name (First, Middle,	5+	Hon	emaker	18. Mother's Nam	- (First Middle 1	Own Ho	
Maryland	should be filed within 7: n and Mental Hygiene. 7 is marked other than raumatic event, the Me	To	George Austin	· ·			1	: Glass :		3)
lary	should and M is mai		19a. Informant's Name/Relations				and Number or Rura			
2	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Joanne Pancoas	: / Daughter 						rginia 22150
Baltimore,	age 1 and of h		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation		te 20b. Place of Disp cemetery, cr	ematory or other place	ery July	Date 1.6 2012		- City or Town, State
alti.	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (3		ROCK OI	22. Name and Addre	ess of Facility Jos	eph Gaw		
ä	Der Jany		W. Cluth	Musin		5130 Wisc	onsin Ave	. NW Was	shington	n, DC 20016
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that dadsonly one cause on each li	ed the death. Do not er ne.	ter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	_ a.	c Obstruct:	ive Pulmon	nary Disea	ase / Em	physema	a 10 Years
	Examiner			Due to (or as	s a consequence of):					
	_ =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or an	s a consequence of,:					
	and rans	xar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
0	death certificate be executed the attending physician and ed for use as the burial ransit	dical			,					
8760	ificate ng phy as the		IF FEMALE:	1					1	10 -
<u>ت</u> ×	aath certifica attending ph I for use as t	ian/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3		су			ate of delivery
P.O. Box 687	the at	Physician/Me	1 Yes 2 No	4 ☐ Pregnant 9 ☐ Unknown		Other (specify)			IVIO	onth Day Year
0	requires that the dea been signed by the a should be detached	by Ph	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use conti	ribute to the cause of death?
ds,	quires en sign buld b	ted k						1 🔀 Y	′es 2 □ No	3 Probably 4 Unknown
CO	law re nas be e 2 shi	Completed						24a. Was a autop:	sy	Were autopsy findings available prior to completion of cause of death?
8	Physician: The law this certificate has al director, page 2		25. Was case referred to medical	_				1 🗆 Yes		1 Yes 2 No
/ita	/siciar s certif	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	atient 2 ER/Outpati	Oth	lace of Death (Checi er:	ome 5 X Reside	ence 6 Othe	er (Specify)
of	ng Phy ter thi ineral		27. Manner of Death 1 ** Natural 5 • Pendi	28a. Date of in	jury 28b. Time		y at	28d. Describe ho		
ion	tendii death. tor: Ai	Certificate:	2 Accident Investi	gation not be		M 1 🗆	Yes 2 ☐ No			
Division of Vital Records,	l or At after Direc d in by		4 ☐ Homicide detern	lined 286. Place of In building, e	njury - At home, farm, s etc. (Spec <i>ify)</i>	treet, factory, office		28f. Location (SI City or Town		er or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical		Physician: To the best of						ner as stated. te to the cause(s) and manner stated.
	the H thin 24 the F mplete	Me		Nurse Practitioner: To t		e, death occurred at	the time, date and pla	ace, and due to th	e cause(s) and n	manner as stated.
			And the signature and the or centile	-d-110		29c. Licens	065 4241	1	4	d (Month, Day, Year) 9/12
	10		30. Name and address of person Deidra Woods 1	who completed cause of	death (Item 23a) (Type					
						ue Suite	1400 Chev	y Chase	, MD 20	
	Stat Registra	te ar	31. Date filed (Month, Day, Year)	012 Lengist	trar's Signature	and a				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 5, Barbara Peake 2012 2:00 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Golden Living Frederick If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Days Min 134-16-2771 101 Director 1 🗆 M 2X F March 13, 1911 Pennsylvania Usual Residence of Dec show 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 28a-f Maryland Frederick Walkersville 1₺ Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21793 8891 Triumphant Court USA items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify white Specify: 3 Widowed 4 Divorces Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Retail clerk Department store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever Barbara Kamerich John Kasun, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Maxwell - daughter 8891 Triumphant Court, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Stauffer Crematory 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State 7-9-2012 Frederick, Maryland 21702 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Conowny Anteny Physician/ ATHERO SCLENOSI disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner MENTIN Sequentially list conditions, Examiner Due to for as a consequence of ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events executed sician and burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ending physical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year signed by the at d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe has e 2 certificate has lirector, page 2 1 🗆 Yes 2 🗆 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ြုင 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural Accident 5 Pending n 24 hours after death. The Funeral Director: All oletely filled in by the fu Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complet the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOU HOUSE AVE PREDERICE 814 ·KAZMI, MM 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July ^{Day}012 Otis J. Prichard 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Casey House Hospice Rockville Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Director 215-52-8528 59 1 X M 2 □ F Yrs Nov. 3, 1952 West Virginia ms 23a or 28e-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Maryland Montgomery 1 Yes 2 No Boyds 10e Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 23735 Slidell Road 20841 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Worker Construction treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental I is marked o ျှ 0tha Prichard Marceline Remsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Virginia Prichard - Wife 23735 Slidell Road, Boyds, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
eny Injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Other (Specify) Resthaven Mem. Gardens 7/10/12 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Molesworth-Williams P.A.,
26401 Ridge Road, Damasc Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day ed by the at detached for 9 Unknown P.O. To the Hospital or Attending Physicien: The law requires that within 24 hours after death.

To the Lunete Director: After this certificate has been signed I completely filled in by the funeral director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 24 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖔 Other (Specify) HOSPice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 🗀 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Acertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, R143201 7.5.12

DHMH 17 Rev 06-2011

State Registrar 6001 Muncaster Mill Road,

Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

Debrah Miller,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 1^{Day} 2012 0340 Sarah Louise Peterson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 2528 Appleton Road E1kton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. FEB 3, 1928 1 □ M 2 👿 F Delaware **Director** 212-26-0388 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland E1kton 1 ☐ Yes 2 👿 No Ceci1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2528 Appleton Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetic. Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Corporate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Ernest Hook Lola Rebecca McCall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Wanda S. Clevenger/Daughter 2288 Looney's Creek Road, Grundy, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of F v 17. Cherry Hill or other place) Methodist Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cherry Hill. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): ¥. Cause (Disease or iinjury The law requires that the death certificate be executed burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗷 No for Day Month Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown plnous 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? certificate Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical director, Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 KNatural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

Billon

John A.

		1	State of Maryland / Department of Health and Me	ental Hygien Reg. N	for U I for	23643
		Į.	Registrar	2. Date of Death		3. Time of Death
	Physicia		1. Decedent's Neme (First, Middle, Last)	July 6	2012	8:50 A ^M
	/Medic	al	wyhonia katherine krenarason		Ic. County of Deatl	
	Examin	er '	ia. Facility Name (ii not visitable), give sites, and noticely		Calvert	
			Calvert Memorial Hospital Prince Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtl	hplace (State or Foreign
	Funeral		Months Days Hours Min.	(Month, Day, Yea 11-13-193	9 Wasi	h., D.C.
	Director	-	Usual Residence of Decedent	11 10 170	,,,,,,,	
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many fred	to	MD Anne Arundel Lothian			1 ☐ Yes 2 🔀 No
	1 the	Director	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Co	untry?
	3a o		427 Dutch Drive 20711		USA	
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forceş? 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto f	city Yes or No- Rican, etc.)	14. Race - Ame Black, White	
9	after or Ite		1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 1 Yes 2 M No Specify:		Specify:	
8	tiled within 72 hours atter death with the Maryland Hygiene. ther than "natural", or tems 23a or 28a-f show ther than "natural", or tems 23a or 28a-f show ant, the Musical Examinar must be notified at	d by	3 🕅 Widowed 4 □ Divorced Year or Dates:	16h	. Kind of Business/	hite
2	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin life, DO NOT use retired)		. Killa of Basillosa	madetty.
2	han within	mp	Elementary/Secondary (0-12) College (1-4or 5+) 2 sales associate & manage	er De	partment	Store
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Maryland 21215-003	should be and Mental I smarked o	Be c	William Louis Clerico Josephi	ine Wyno	nia Br	inkley
2	thouling Me	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		ty or Town, State, 2	Zip Code)
<u>≅</u>	nd 2 s Ith ar 27 is 1 trau		Darlene Mingioli, Sister 3611 Yellow Bank Rd.,	Dunkirk,	MD 2075	4
စ်	Hea Hea tem	10.	20b. Place of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition Disp		. Location - City or	Town, State
JUO	ages ant of nt: If i		1 M Rurial 2 □ Cremation 3 Removal from State	0-2012 B:	rentwood.	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show amy righty or other traumatic event, the Musical Examiner must be rutified at ance. ance.	1		ausch Fune		
m	Dep Imp		Milliam R Green MOO715 8325 Mt. Harmony La	ane, Owing	s, MD 2	0736
	_ = 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between Onset and Death
0	Physician	Ìη		ncer		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			
В	Examiner		Sequentially list conditions b.			-
	P #	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying			
	and trans	Examiner	Cause (Disease or injury that initiated events c			
8760,	cate be executed oblysician and the burial-transit					
87	death certificate be executed e attending physician and ed for use as the burial-transit	Physiclan/Medical	d			
9 X	death certifica attending phater use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	slivery
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0.	that the de ed by the detached	ıysi	1 ☐ Yes 2 MNo 9 ☐ Unknown			
	es that the igned by th be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac		to the cause of death?
sp.	uires sign	d by	Chronic obstructive Air way disease	1 Yes	2 □ No 3 □ F	Probably 4 Unknown
Vital Records,	law requires as been sign 2 should be	ompleted	Hypertensive Heart direase	24a. Was an	24b. Were a	autopsy findings available ocompletion of cause of
Re	e <u> </u>	mg	Trypetre justice the second	autopsy performed 1 ☐ Yes 2 🛣	d? death?	,
a	ician: The certificate rector, pag	S	25. Was case referred to medical 26. Place of Deat	th (Check only one)		
Ξ		O B	examiner?	ome 5 🗆 Residenc	e 6 □Other (Sp	ecify)
of	Phys or this oral di	-	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28d. Describe how	injury occurred	
on	Attending I r death. ector: After by the funer	ig ig	1 Natural 5 ☐ Pending (Month, Say Year) 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	il or Attendii after death. Director: A d in by the fu	E	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S		Rural Route Number,
Ö	al or A s after al Direct	Certification:				
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the caus rred at the time, date	se(s) and manner a and place, and di	as stated. ue to the cause(s)
	the H nin 24 the F splete	Medical	one) and manner stated.		I. Date signed (Mo	
\	To To	2	29b. Signature and title of ortifier Swone 9 50653		7 - 6	
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)	RW 5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (17) N C.	SURAN	T 21	0751
0			31. Date filed (Month, Day, Year) 32. Registral Signature	1 / / / / / / / / / / / / / / / / / / /	1) 0	
	Regis	trar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. 5851 - Reule Churchen Read Dea 31. Date filed (Month, Day, Year) 32. Registral Signature 34. Aparel			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ELIZABETH M. RYAN ZDay Year 0035 M JUNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours 470-38-9964 **Director** 1 □ M 2X) F 74 4/18/1938 MINNESOTA if Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28a-f ehow other treumetic event, the Medical Examinant by multified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TALBOT EASTON 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 528 SOUTH AURORA STREET 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be file of Health and Mental H I tem 27 is marked o JOSEPH MOHAR ANN STRUKEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. JOHN M. RYAN, HUSBAND 528 SOUTH AURORA STREET, EASTON, MD Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 e
Department of H
Importent: If ite
eny injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) WOODLAWN MEMORIAL PK 4 Donation 5 Other (Specify) 6/29/2012 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON STREET EASTON, MD 21601 Bal JOHN R. MERCER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atheroscienotic Heart Discase Physician/ Medical resulting in death) Examiner CHROMIC ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The lew requires that the death certificete be executed tor: After this certificate has been signed by the ettending physicien and the funeral director, pege 2 should be detached for use es the buriel-tran resulting in death) Last Physician/Medical RHermatorp Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UPPER GASTROINESTINAL NEMBERCHASS 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Extremita Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 မ 1 Yes 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after de To the Funerel Directo Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner/ to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) LAT leted cause of death (Item 23a) (Type, Print) s. WasHmgton st. EASTON 114

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar TLS, TCHD, 6/28/2012 mended 26. Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Physician/ 24Day 2012 JÜNE 7:10 AM JANE HUDSON ROSS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death TALBOT **EASTON** TALBOT HOSPICE HOUSE If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Year) 231-32-2138 Director 1 □ M 2 🛣 F 79 APRIL 6, 1933 **VIRGINIA** Usual Residence of Decedent show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl MD TALBOT **EASTON** 1X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 611 ELWOOD AVENUE 21601 USA should be filed within 72 hours after death "natural", or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Specify: WHITE Year or Dates intal Hygiene.

ked other than "nature
e event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ဂ္ ETHEL E WACHSMUTH JOHN GUY HUDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DC 20008 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3133 CONNECTICUT AVENUE, NW, APT. 1103, WASHINGTON KIRK B. ROSS, SON Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/2012 TAPPAHANNOCK, VA **ESSEX CEMETERY** 4 ☐ Donation 5 ☐ Other (Specify) Funda ervice Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 21601 200 SOUTH HARRISON STREET, EASTON, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List only one cause or Onset and Death Immediate Cause (Final ARCINOI Provincian/ TUMOR OF THE 429 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner VER META Eequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BRONGHITTE or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👺 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 2 W No 1 Yes Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE Hospital 1 Yes 2 No Other: ျ 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 nce 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Hospital 24 hours Medical 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Daty, Year) 2 nic TIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC F. CIGANEK, MD 629 RAILROAD AVENUE, CENTREVILLE, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature JUN 2 8 2012 Registrar

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bert Ridgeway	/	State of Maryland / Department of Health and Mer								giene		21	0 1 1	2 2364
		1- For State Registrar		Certi	ificate o	f Death					Reg. No	. 4	Uli	2 2004
Physicia		Decedent's Name (First, Midd	dle,Last)						2	. Date of D		· .	T:	3. Time of Death
edical Exami		Robert War	ren Ridg	OMON						Month July 3, 2	Day	Yea	r	2053 hrs
		4a. Facility Name (if not institution				4b. City, To	wn or L	ocation of	Death	ouly o, z		4c, County o	f Death	
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under		If Under Hours	Min.				Foreign	place (State or Washington
Director		579-58-7433	1XM 2F	65	Yrs		Days	riodio		May	1, 1	.947	Cour	ntry) DC
		Usual Residence of Decedent		•			-							
any		10a. State 10b. County		10c. City, To	own or Loca	tion								10d. Inside City Limits
Pe po es	닐	MD Dor	chester					Cam	brid;	ge				1 Yes 2 X No
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nours xam	핗	15. Decedent's Education (Spe			16a. Deceder	nt's Usual O nost of worki					16b	. Kind of Bus	siness/In	dustry
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Set it it it it it it it it it it it it it	튑	12			1.60	deral	Age.	IΙL			U	.S. G	over	nment
ed w	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Osual Occupation (Give kind during most of working life. DO NOT us 12 Federal Agent 17. Father's Name (First, Middle, Last) 18. Mother's I							Name (F	ame (First, Middle, Maiden Surname)					
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she te event, the Medical Examiner must be notified at once	Ernest B. Ridgeway Dor						ris .	Arnol	d					
Mer Mer	2	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	ng Address	(Street	and Numb	er or Ru	ral Route N	lumber,	City or Towr	n, State, i	Zip Code)
MD id 2 shot ulth and m 27 is	99 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 -						Roa	d, Car	mbri	dge.	MD	21613		
and and teen trem		20a. Method of Disposition		20b. Pla	ace of Dispo					Date		. Location -		own, State
More, MD Pages I and 2 sh nent of Health an ant: If item 27 is or other trauma		1 Burial 2 X Crematio	on 3 Removal f		ematory or of		-		- /-	140			_	_
Pag nent		4 Donation 5 Other S	Specify:	Gren	natory							De1ma		
Baltimore, permit. Pages I as Department of Her Important: If ite		21. Signature of Funeral Service	e Licensee		22, 1	Name and A	ddress o	of Facility	Thoma	as Fu	nera	1 Hom	е P.	Α.
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Physician		23a. Part I. Enter the disease, o failure. List only one cause		caused the death. D	Do not enter	the mode of	dying, s	uch as ca	rdiac or r	espiratory a	arrest, s	hock, or hea	irt	Approximate Interval Between Onset and
/Medical		immediate Cause (Final disease	A 4 h	erotic Cardiovas	scular Dis	sease								Death
Examiner		or condition resulting in death)		a consequence of):							_			
		Sequentially list conditions,	b.											
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Box 68760, e death certificate be ex the attending physician of for use as the burial.	an/Medi	IF FEMALE:		outcome of pregna	ancy						2	3d. Date of	delivery	
rtific ring p	Jug	23b. Was decedent pregnant in t past 12 months?	the 1 Live	birth	2 F	etal death	3	Ectopic	pregnand	у		Month	Da	ay Year
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ires that the signed by I be detach		Part II. Other significant condi	itions contributing	to death but not res	sulting in the	underlying o	ause giv	ven in Par	t I.					ne cause of death?
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tal Recian: The	Be (25. Was case referred to medica				26		of Death (0	C heck on	ly one)				
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸 E	R/Outpatien	nt 3 🗌 00	A C	Other 4	Nursing	Home 5	Resid	dence 6	Other:	
ing Ph	<u>-</u>	27. Manner of Death		e of Injury th, Day,Year)	28b. Time of	Injury 28	Bc. Injury	at Work?	2	8d. Describ	e how i	njury occurre	ed	
Be für	Ö		nding	ii, Day, real)			1 Ye	es 2 🔲 I	No					
Affe ar dea ecto	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building,					ildina. etc	2	8f. Location) (Street	and Numbe	er or Rura	al Route Number, City		
Divi	Certification:	dete	uld not be ermined (Specify		,						, State)			
the Hospital hin 24 hours the Funeral		4 Homicide	(0,000,00)	•										
n 24 h	ca	(Check only	Physician: To the be aminer: On the basis											
To th	ledical	2 🛡	and manner		aror investiga				uned at t	ine time, da				
	Ž	29b. Signature and title of certifi	ier			29c.	License	number			290	d. Date signe	ed (Mont	th, Day, Year)
			201 11				O.C.N	1.E.			Ju	ily 4, 201	2	
-		30 Name and address of negen	on who completed car											

State Registrar DHMH 17 Rev 1/2001 OCME 2006

Jack Titus MD.

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Virginia Reid 2012 0400 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Rehabilitati Salisburg 8. Date of Birth g. Birthplace (State or Foreign Social Security Numb **Funeral** Months Hours July 29, 1929 Mary Tand 82 220-28-1664 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 200 Civic Avenue 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. White 3 XWidowed 4 Divorced Completed 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carl Henry Steininger Alma Eubank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 1018 Beaglin Park Drive, Apt. 204, Salisbury MD Rose Kelly/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/6/2012 4 Donation 5 Other (Specify) Crematory Of Delmarva Delmar, Delaware 22. Name and Address of Facility Zeller Funeral I2I2 Old Ocean eture of Fineral Service Mc Home, Pado. 21804 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated event in the cause) Examin and -transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy □ Live Birth 2 □ Fetal dea□ Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 1 Yes 2 signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an cate has page 2 s autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🔀 No 1 🗌 Yes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07-05-2012 29505

Registrar

State

5302

CHINABERRY DR., SALISBURY, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOSO,

M. BEL

GREGORIO

James H. Rand II

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		-	For State		State	of Marylar		artment of I <i>tificate of L</i>		and Mental Hy		00	3 1	0 0001
			Registrar 1. Decedent's Name	(First, Middle, L	.ast)		Cei	uncate of L	Jeann	2. Date of De		1-	-	3. Time of Death
f	Physicia Medio		JAMES HAM	ILIN RAI	ND IV					July	5	30 i	ear 2	18:58 AM
	Examin		4a. Facility Name (if r				NTED	4b. City, Town, o		of Death		C. County of NNE A		DET
	Funeral		5. Social Security Nu		. Sex	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. 8. Date of Bi Min. (Month, Date	rth			place (State or Foreign
È	Director		004-34-714 Usual Residence of		1 🏋 M 2 🗆 F	76	Yrs.	WIGHTIS Days	Flours	6/13/1			MAI	
	land show dat	tor		10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	MARYLAND 10e. Street and Num	ANNE AI	RUNDEL	MIL	LERSVI	LE 10f. Zip Code			100	1A1	-1.0	1 🗆 Yes 2 🗓 No
	with th	Funeral I	326 COOL		COURT			21108				itizen of Wh		-
	death items ner mu		11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Nas Decedent of H	lispanic Orig	gin? (Specify Yes or No n, Puerto Rican, etc.)		14. Race - Black,	Americ	can Indian,
336	s after al", or Exami	d by	1 ☐ Never Marrie 3 ☐ Widowed 4		If Yes, Gi	2 □ No ve lates. 1955		I □ Yes 2 🗓 No	Specify:			Specify:	WHI'	
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	filed wall Hygial Hygial of othe	Be	17. Father's Name (F.	irst, Middle, Las	rt)		ANA	1151	18. Mothe	er's Name (First, Middle				
Maryland	uld be I Ment narke natic e	10	JAMES H.							IRLEY PORTE				
Ma	12 sho alth and 27 is i		19a. Informant's Nar				100			er or Rural Route Numb OURT MILLER				
ore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo	osition	☐ Removal from	20b.	Place of Diene	sition (Name of		Date	20c. L	ocation - Ci	ity or To	own, State
Baltimore,	it. Page rtment rtant: njury o		4 Donation	5 Other (Spe	ecify)	CEM	ETERYLI	natory or other place. LE VETERA	INS 7	7/10/2012 LASTING TR		WNSVI		
Bal	permir Depar Impor any ir once.		21. Signature of Fun	524			Ħ1	LY ENBELD	TE RE	WNAM CREMA	TION	MD 21	ŊĘŔ	AL CARE
r		П	23a Dat 1. Enter the	e disease, or co	implications that y one cause on e	caused the dea	th. Do not ente	er the mode of dyin	ng, such as	cardiac or respiratory a	rrest,			Approximate Interval Between
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Division of Vital Records, P.O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicistely filled in by the funeral director, page 2 should be detached for use as the bu	/Me	IF FEMALE: 23b. Was decedent p	prognant		tcome of pregn				· · · · · · · · · · · · · · · · · · ·		23d. Date	of deliv	en/
Box	death c le atten ed for u	sicial	in the past 12 m	nonths?		Birth 2 Fergnant at time of		Ectopic pregnand Other (specify)	СУ			Month		Day Year
0	s that the death gned by the atte be detached for	, Phy	9 Unknown Part II. Other signific	cant condition			sulting in the u	inderlying cause gi	ven in Part	l. 23e. Did	tobacco	use contribu	ute to t	he cause of death?
IS, F	requires the been signer should be	ed by								1 🗆	Yes 2	. □ No 3	₽ Pro	bably 4 🗆 Unknown
corc	aw req as bee	plet								24a. Was	DSV	pric	or to co	psy findings available impletion of cause of
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of	ding Ph h. After thi funeral	ate:	27. Manner of Death	5 Pending	28a. Date		28b. Time of injury	28c. Injur work	y at	28d. Describe				
sior	Attend r death ctor: /	rtific	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determine	t be 28e. Plac			M 1 L eet, factory, office	Yes 2		Street ar	nd Number o	or Rura	Route Number,
Divi	rtal or units after all Direction to led in the	al Ce	4 🖂 Homiciae	determin	build	ling, etc. (Speci	fy)			City or To	wn, State	e) 		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certificate:	(Check 2	.Medical Exa	miner: On the ba	sis of examination	on and/or inves	tigation, in my opini	on, death oc	I place, and due to the occurred at the time, date at and place, and due to	and place	e, and due to	the ca	use(s) and manner stated.
	To the within To the compl	Σ	only one) 3 29b. Signature and to	itle of certifier			Thy knowledge	29c. Licens		ite and place, and due to		ate signed (/		•
			► mk		ACOP-				750	29	ال	145	, 6	1012
	18/1		30. Name and addre	. 3		. 1	m 23a) (Type, F Sρital		ken B	Surnie M	0 3	2106	1	
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Walter Raymond Rickards, Jr. Walter Raymond Rickards, Wife Walter Walter Walter Walter Walter Walter Walter Walter Walter Walter Walter Walter Raymond Rickards, Wife Walter	12-05400 Walter Raymond F	1- For State Certificate of Death	Hygiene 20	2 235
## As Feeling Manney (for distallations, you be most and number)			2. Date of Death Month Day Year July 18, 2012	
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Physician Medical Exeminer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially its conditions, state contributing to death Due to (or as a consequence of): Sequentially its conditions, state contributing to death Due to (or as a consequence of): Due	land f show any pace.	10a. State		10d. Inside City Limits
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Physician Medical Examiner 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 25a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 25a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 25a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 25a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 25a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 25a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock, or	altimore, mit. Pages I an partment of Hea pportant: If iter ury or other tra	1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Ju	ily 21, 2012 Smiths	burg, MD
Medical Examiner Medical Examiner Medical Examiner Medical Cause (Final disease or condition resulting in death) Medical Cause (Final disease or conditions resulting in death) Medical Cause (Final disease or conditions resulting in death) Medical Cause (Final disease or conditions resulting in death) Medical Cause of death Medical Ca		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		MD 21701 Approximate Interva
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We have the composition of the c	ecuted and transit	d.		
23b. Was decedent pregnant in the past 12 months? 1	50, te be ex lysician burial			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 Yes 2 No 2 Yes 2 No 2 Yes 3	Sox 687/death certificate attending plor use as the	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pre 5 Other (Specify)		
24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1	s, P.O. E	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
25. Was case referred to medical examiner? 1	Records The law requicate has been page 2 shouls		autopsy prior to c performed? death?	completion of cause of
28d. Describe how injury occurred Subject exposed to high Investigation Suicide	F Vital Physician: r this certif al director, To Be (examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nu	rsing Home 5 Residence 6 🗸 Other	r: Scene
25. Location (Street and Number of Rural Route Number, City of Town, State) 1155 Key Pkwy. Specify Sp	Sion o Attending r death. ector: Afte by the funer cation:	1 Natural 5 Pending Investigation Investigation Pending Investigation Investigation Pending Investigation Investigation Investigation Investigation Pending Investigation	subject exposed temporal tem	perature
HI SI IN I (Check only 11 Gentlying mysician, 10 the best of my knowledge, death occurred at the time, date and diace, and due to the cause(s) and manner as stated	Divi lospital or thours afte uneral Dir ily filled in	Suicide Could not be determined (Specify) Major Road/Highway 29a. Certifier 4 Could not be determined (Specify) Major Road/Highway	or Town, State) 1155 Key Frederick, MD.	Pkwy.

25. Was case referred to medical		26.Place of Death (Check	only one)
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursin	ng Home 5 Residence 6 🗹 Other: Scene
27. Manner of Death	28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending	(Month, Day,Year)	1 Yes 2 X No	subject exposed to high environmental temperature
2 X Accident Investigation	fd 7-18-12 fd 14:51	om	environmental temperature
3 Suicide 6 Could not be determined	28e Place of Injury - At home farm street far	ctory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1155 Key Pkwy. Frederick, MD.
one) 2 Medical Examiner:			
29b. Signature and title of certifies	and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)
Efle Grass	ull MS	O.C.M.E.	July 19, 2012
30. Name and address of person who co	ompleted cause of death (Item 23a)		
Melissa Brassell, MD Ass	sistant Medical Examiner 900 W. Ba	altimore Street, Baltimo	ore, MD 21223
31. Date filed (2014, 2012)	32. Registrar's Signature		

State Registrar

		Please T	ype or Print i							_egible	
		For State Registrar	State of Maryla		artment of F <i>tificate of L</i>		and M	lental Hy	giene Reg. No.	201	2 2265
Dharisia		Decedent's Name (First, Middle, Last)			imodeo or z			2. Date of De	eath	L U +	3. Time of Death
Physicia Medic	al	Maria Staymates						July	,	2012 Year	14:46 M
Examine		4a. Facility Name (if not institution, give str 13443 Cherry Tree	Circle		4b. City, Town, o	town			Was		on County
Funeral Director		5. Social Security Number 219-66-0978 Usual Residence of Decedent	M 2 X F 87	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da June	ay, Year)	Co	thplace (State or Foreign buntry) Prmany
aryland a-f show fied at	Director	10a. State 10b. County Maryland Washington		City, Town or Low							10d. Inside City Limits 1 ☐ Yes 2X No
ith the Mi 3a or 28 t be noti		10e. Street and Number 13443 Cherry Tree			10f. Zip Code 217					en of What Co	ountry?
eath wi	Funeral		2. Was Decedent Ever in	U.S. 13. \	Vas Decedent of H	ispanic Orio	gin? (Spec	cify Yes or No-		Race - Ame	
urs after de ural", or it I Examine	ğ	1 ☐ Never Married 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		f Yes, specify Cuba	,		Rican, etc.)	Sp	Black, Whit pec <i>ify:</i> Wh	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done of NOT use retired)		t of workin	ıg		of Business	/Industry Residence
be filed wi ental Hygid ked other c event, t	To Be (17. Father's Name (First, Middle, Last) Rudolph Hopf		Homen	IAKEL			(First, Middle,			esidence
2 should Ith and Me 27 is marl traumati		19a. Informant's Name/Relationship (Type Arthur Staymates-I			ng Address (Street)	and Numbe	er or Rural	Route Numbe			·
of Heal		20a. Method of Disposition	201	b. Place of Dispo				ate		ation - City o	
t. Page tment tant: h		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		est Have	n Cemete	ry				stown	
permir Depar Impor any ir		21. Signature of Funeral Service Licensee	12001-1-		Name and Addre B31 Easte		,	_		,	eral Home MD 21742
Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition									Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	2750.0	70CC	1 00	270 (i- VISADI
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):	R128C11	/1					2 CRNKY
ecuted and II-transit	zaminer	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a cons	equence of:							
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To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → Vo 9 □ Unknown	c. If yes, outcome of pred 1 Live Birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnand Other (specify)	Э			23	d. Date of de Month	elivery Day Year
that that that that the	by Pr	Part II. Other significant conditions cont	- :	0	, 0	ven in Part I	l.	23e. Did t	tobacco use	contribute to	the cause of death?
equires	eted	1896 2 DIACETE	- /	PHYROI	W			1 🗆			Probably 4 Unknown
Physician: The law r r this certificate has b rral director, page 2 s	Compl	AGRELIANSM	(9					24a. Was auto perfe 1 \square Yes		prior to death?	rtopsy findings available completion of cause of
sician: certific lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 40	spital:		_ Oth	ace of Deat					
ng Phy ter this meral o	te: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of		y at		ne 5 Nesi 8d. Describe			orty)
or Attendir fter death. irector: Af ire by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, stre	M 1 🗆	Yes 2 🗌		28f. Location (City or To		Vumber or Ru	ıral Route Number,
Hospital of the hours at Euneral D tely filled i	Medical C		ian: To the best of my knor: On the basis of examina								tated. cause(s) and manner stated
Fo the I within 2 Fo the I	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best	of my knowledge,	death occurred at t		te and plac	ce, and due to		and manner a signed (Mont	
			Mp			0622			July	713,	2012
W-10		30. Name and address of person who con	npleted cause of death (If	tem 23a) (Type, F	rint) MKMM	WVIK	WOR	ARM	rettin.	UN MY	021742
Stat Registra		31. Date filed (Month, Day, Year) 6 2	32. Registrar's Sig	nature	Sall	10	-101	APSOLUTION OF THE PROPERTY OF			- Oc. 1 - V

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Elizabeth Marie Stein June 30, 9:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospice Dove House Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-32-9773 83 Hours Director 1 M 2 X F Nov 13, 1928 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Carroll Taneytown Maryland 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 156 Saddletop Drive 21787 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Was Decedent Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: white 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ludwig Schuster Marie Gruber 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is nany injury or other tremone. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Horak, daughter 1937 Gardenia St, Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemeta Ora Touron or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/2/2012 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) a consequence of): Oyels Medical Due to lo Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown or Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🖒 Hospital: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury Natural injury 5 Pending after death. Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) K101027 0 Di

Registrar

DHMH 17 Rev 06-2011

State

292 Stanev
31. Date filed (Month, Day, Year)

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32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Day Joann Vincentia Sobotka 2012 6:20 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County 4420 Black Rock Road, Apt. Hampstead If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 219-32-2269 **Director** 1 □ M 2 🗶 F 74 1937 Maryland oct. 4, 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland Carroll County Hampstead 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be 23a Funeral United States 21074 4420 Black Rock Road, Apt. Page 1 and 2 should be filed within 72 hours after death intent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Widowed 4 X Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) office manager charity Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bernice Tomalski Joseph Sobotka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manchester, Maryland 21102 Michael R. Wolinski 4430 Hayfield Drive 20b. Place of Disposition (Name of cemetery, crematory or other place Carroll Cremation 20a. Method of Disposition 20c. Location - City or Town, State July Data permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Hampstead, Maryland 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the b IF FEMALE: JSe a yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Month Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig 2 No 3 Probably 4 Unknown 2.45. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform Yes 2 No After this certificate 1 🗌 Yes Be 25. Was case referred to edical examiner? 26. Place of Death (Check only one) 2 1 No Hospital: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) vificate: T 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, icide determined City or Town, State) Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Aurise Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifier (Check only one) .9b. Sign ture and titl 29c. License number 29d. Date signed (Month, Day, Year) 23848 nd address of who completed cause of death (Item 23a) (Type, Print) 84

WH A State

Registrar

31. Date filed (Month, Da

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istrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		P	ease									All Copie: /lental Hy		Legit	ne.		
	1	For State Registrar		State	JI IVIA	ryiaii		tificat			ariu i	-	_	20	1	2 2351	5
Physician/	1	1. Decedent's Name (First, Mi	ddle, Las Sab					***************************************	<u> </u>			2. Date of De Month	Day		ear	3. Time of Death 10:52 A.M	<u>ر</u>
Medical Examiner		a. Facility Name (if not institu						4b. City	Town, or	Location	of Death	Oury 5		County of	Death		_
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Funeral Director		. Social Security Number 265–44–3783 Usual Residence of Deceder	_	ex □ M 2 X F		(in yrs. la 79	sst birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Birl (Month, Da Jan. 22	y, Year)		Coun	place (State or Foreign itry) York	1
or 28a-f show notified at		MD 10b. Cou	,	ry		-	r, Town or Lo tgamer		llage)					1	10d. Inside City Limits 1 Yes 2 □ No	
tems 23a or ser must be no		0e. Street and Number 10006 Stedwic	k Ro	ad #202	2				0886				10g. Citiz Unit	en of Wh	at Cour		
y, or min	2	1. Marital Status 1 Never Married 2 3 Widowed 4X Divor		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 X N ve	er in U.S o		f Yes, spe	cify Cuba	spanic Ori n, Mexical Specify	n, Puerto	ecify Yes or No- Rican, etc.)			White,		
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nd 2 shoul salth and I n 27 is m er trauma		19a. Informant's Name/Relati Lisa Sabra/Da										al Route Numbe 202 , Mo n				ode) age,MD2088	6
Page 1 arment of He cant. If iter		0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 4 🕱 Donation 5 ☐ Oth	er (Specif	5/)	state	Geo:	lace of Dispo rgetow ical C	ກິ ^{to} ໃນກໍ: ent.e:	ivers :	- 1		ly 3 012	20c. Location - City or Town, State Washington, D.C.				
permit Depart Import any in	(21 Signature of Funeral Servi	ce Licens	els	_/\	1009	- 22	. Name a	nd Addres	s of Facili olis	ryCoIt Road	umbia M d,Lanha	ortua m,MD	ry S 2070	erv. 6	ices, P.A.	
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Examiner		resulting in death) Sequentially list conditions,	ſ	b. ———	(or as a	,											
be executed sician and burial-transit cal Examiner		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ና	C			ence of):										
		_	L	d									- 1				
To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriatral Medical Certificate: To Be Completed by Physician/Medical Exa	- 22	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23c. If yes, ou 1 Live 4 Prec 9 Unk	Birth 2 gnant at t	Feta	Ideath 3 🛚	Ectopic Other (s		у			2	3d. Date Month		ery Day Year	
uires that to a signed by uld be detailed by Pl	3	Part II. Other significant con	ditions co	ontributing to o	death but	not resu	ulting in the u	nderlying	cause giv	en in Part	l.	23e. Did to		1		ne cause of death?	1
The law require sate has been si page 2 should I		-										24a. Was autor perfo 1 \square Yes		prid dea	or to co ath?	psy findings available mpletion of cause of	
cian: ertific ector,		25. Was case referred to medi examiner?		Moonital							th (Checi	k only one)					_
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or Attending P after death. Director: After the fine by the funera		1 Natural 5 Pe 2 Accident Inv	nding estigation uld not b	(Mor	nth, Day,	Year)	injury	М		Yes 2		28d. Describe h					
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2		· a s	lu	dma		m	R	Ī	37	80			Jul	4 9	, 2	2012	
	3	30. Name and address of pers Aimee S		completed causes		ith (Item	23a) (Type, F	Print)	150 Roc	20 S	hady le. 1	Grove 3	Road	Suit	e 3	00	
State Registrar	3	1. Date filed (Month, Day, Yea JUL 1	r)	3 / 2. F	Registrar'	s Signat	fa.	W	1100			2000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ju_{y}^{Month} 6, 20124:30 Ам Stamper Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Frederick Villa Nursing & Rehab Catonsville 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthdav) **Funeral** Hours 404-34-6719 1 X M 2 □ F March 28, **Director** 1930 82 Ohio Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits 10h County the Maryland **Funeral Director** 1 Yes X No Maryland Baltimore Catonsville , 23a o 10g. Citizen of What Country? 10e. Street and Number U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death with must h 21228 212 D Garden Ridge Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Completed White Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natur any nijury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Curtis Franklin Stamper Nora May Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gregory Stamper 212 D Garden Ridge Road, CATONSVILLE, Md. 21228 Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 13, Date 2012 cemetery, crematory or other place) July 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Georgetown Cemetery Georgetown, Kentucky Signature of Funeral Service Li WITTIAMS Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, M00668 Md.20640 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the shock, o hear disease, or complications that caused failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cluse (Fi Final Physician/ aschlar Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 1 Yes 2 No certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🔲 Yes 2 🗆 No

within 24 hours a

To the Funeral C

completely filled 0 فار BO. 4,

Medical

27. Manner of Death

1 X Natural

☐ Accident ☐ Suicide Suicide

4 Homicide

only one) 29b. Signature and title of certifie

Raymond

31. Date filed (Month

29a. Certifier

5 Pending Investigation

Miller

Could not be

rand Mille MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO

Box

1525

egistrar's Signature

determined

Registrar DHMH 17 Rev 06-2011

State

owings mills MA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

047683

21117

29c. License number

28d Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7/6 112

29d. Date signed (Month, Day, Year)

	end 20b F.D.		ID/KW	ase Type or	Print in I							_	le.	
			for State Registrar	Oldio (or ivial ylair		tificate o			nomai ri	Reg. No	20	12	2365
	Dhysicia	/	1. Decedent's Name (First, Middl	e, Last)						2. Date of D	eath			3. Time of Death
	Physicia Medi		Wesley Wy			Jr.				July	4, 2	<u></u> შ12 ^{Ye}	ar	2051 м
	Examir	ier	4a. Facility Name (if not institution 4101 Crain H		nber)		4b. City, Town		of Death			: County of [rince		rang
1	Funeral	Г	5. Social Security Number	6. Sex 1 X M 2 D F	7. Age (In yrs. la	ıst birthday)	If Under 1 Ye	ear If Unde	er 24 Hrs.	8. Date of B	irth		Birthpla	ace (State or Foreign
	Director		514-40-3382 Usual Residence of Decedent	T I I I I I I I I I I I I I I I I I I I	90	Yrs.	Months Da	ys Hours	Min.	Sep	15^{ear}	1921	Vir	ginia
	Maryland 28a-f show otified at	to	10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
	e Man r 28a- notifie	Funeral Director	MD Ca1	vert		wings	Time:							1 🗆 Yes 2 🏝 No
	vith th	ral	2226 Haleys	Way			10f. Zip Cod	e 20736			10g. Ci	tizen of Wha		y?
	eath v	Fune	11. Marital Status	12. Was Dec	edent Ever in U.S	. 13. V	Vas Decedent of f Yes, specify C		rigin? (Spe	cify Yes or No	- T	14. Race - A		n Indian.
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Me Iteal Examiner must be notified at once.	ģ	1 ☐ Never Married 2 ☐ Mar 3 🗷 Widowed 4 ☐ Divorced	If Ven Cit	2 No /e		Yes, specify C			Rican, etc.)		Black, V Specify:	/hite, et	
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212	within giene. er thar the N		Elementary/Seconday (0-12)	College (1	-4 or 5+)		O <i>NOT use retir</i> Career		.ry			US	AF	
pu	tal Hyged other	To Be	17. Father's Name (First, Middle, I	*						(First, Middle	, Maiden	Surname)		_
Maryland	ould be of Men marke matic		William W 19a. Informant's Name/Relations	ycliffe S	awyer, S				thel	-				gley
Z	d 2 shu alth an 1 27 is er trau		Wesley W. Saw		/ Son		g Address (Stre Pat Lan			Route Numb		· Town, State, 0639	Zip Co	de)
Baltimore,	e 1 and of He		20a. Method of Disposition 1 X X Burial 2 □ Cremation		20b. Pi	ace of Dispos	sition (Name of natory or other p			oate 27		ocation - City	or Tow	n, State
<u>t</u> i.	it. Pag rtment rtant; njury c		4 Donation 5 Other (S	Specify)		Vetera	ın's Cer	netery	20	12	_	eltenh		
Bal	permir Depar Impor any ir		21. Signature of Funeral Service I	icensee GOTT		22 8	. Name and Add	dress of Facil nnifer	lity Le Lane	e Fune , Owin	ral I gs, l	Home C MD 207	alve 36	ert, P.A.
6	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. AC	caused the death ich line. (or as a conseque	10CA	r the mode of d	~	a cardiac o	r respiratory a	rrest,		l li	Approximate Interval Between Onset and Death
	executed in and ial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ance of).	RTERY	3 M Q	455)	/FARS
	to the Nospital or Attending Physician: The law requires that the death certificate be within 24 bours after death. To the Funeral Director After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	come of pregnan Birth 2 Fetal nant at time of de nown	death 3	Ectopic pregni Other (specify)					23d. Date of Month	delivery Da	
P.0	requires that the been signed by the should be detach	by P	Part II. Other significant condition	ons contributing to d	eath but not resu	lting in the ur	nderlying cause	given in Part	: I.	23e. Did t	obacco u	se contribute	to the	cause of death?
rds	equire een si nould t	eted								1 🗆	Yes 2			oly 4 🗆 Unknown
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Ea :	clan: ertifica cctor, p	Be	25. Was case referred to medical examiner?		<u>.</u>		26.	Place of Dea	ath (Check		Z JEJI INC		res z	
ž į	Physic this or	유	1 Yes 2 No	Hospital:	Inpatient 2 E	R/Outpatient	3 LI DOA						ecify) 🗜	PALL FIELD
ס עכ	nding ath. : After e funei	cate	1 Natural 5 Pendin 2 Accident Investig	g (Mont	h, Day, Year)	injury	28c. Inj W	jury at ork? □ Yes 2 □	- 1	8d. Describe I	now injury	occurred		
Division of Vital Records,	hospira or Attending Physician: 44 hours after death. Funeral Director: After this certific sted filled in by the funeral director,	Certificate:	3 Suicide 6 Could a determ	not be 28e. Place	of Injury - At hom ng, etc. (Specify)	ne, farm, stre				8f. Location (S City or Tov		f Number or	Rural Ro	oute Number,
_ :	ne Hospit in 24 hour he Funera	Medical	(Check 2	Physician: To the be xaminer: On the bas Nurse Practioner:	is of examination :	and/or investi	gation, in my on	inion, death or	courred at t	he time date a	and place	and due to the	o called	(s) and manner stated.
	ro the within 2 To the comple		29b. Signature and title of certifier					nse number				e signed (Mo		
	0		30. Name and address of person v	Heigh	md	20-1/5		358			Ju	1L Y 5	- 3	012
JP.	<u>v</u> 7	Į,	J84		BEZ	Sa) (Type, Pr	-PRINC	F FR	FAFT	RICL,	M	1-20	6:	18
	Stat Registra	~	1. Date filed (Month, Day, Year)		egistrar s Signatu	re A	ho.v.	1		\				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 12:22 PM Cora Louise Sanford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Beach Calvert 3710 Bayside Road Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days Hours 578-28-7645 Director 1 □ M 2 **X** F Yrs. 11-01-1926 Wash., D.C. 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 ☐ Yes 2 🛛 No Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be Funeral 3710 Bayside Road 20732 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or iter edical Examiner Was Decode... Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White th and Mental Hygiene.
77 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Homemaker</u> <u>Own Home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles **Childress** Isabelle Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 3710 Bayside Rd., Chesapeake Beach, MD Joyce M. Smallwood, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Ft. Lincoln Cemetery 07-12-2012 | Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William RG M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke Years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number

State Registrar

DHMH 17 Rev 06-2011

Charles A

31. Date filed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Rd.

Judge, MD

JUL

D 29657

Ste. 310, Prince Frederick, MD

07/09/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ of Pay July $201^{\circ}2$ 5:15 a M Paul Alfred Sweeney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. 69 Director 1 🏝 M 2 🗆 F 213-42-6392 Yrs 03**–**22*~*-1943 Washington, DC Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1X Yes 2 ☐ No Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 20772 6409 Dowerhouse Road United States items Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. "natural", or iterr edical Examiner r 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify:White 3 Widowed 4 Divorced Completed er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Maryland State Gov't Road Maintenance Worker event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic even ပ S. Sweeney Ethel Moore Alfred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6409 Dowerhouse Rd. Upper Marlboro MD 20772 Paul Allen Sweeney/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ± 5 Department of Important: If any injury or once. July 06,2012Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) .Lincoln Cemetery 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of uneral Se vice Bladensburg Rd Brentwood, MD 20722 Part 1. Enter the dispase, of complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each ine. as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the SB IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Pregnant at time of death detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1. Yes 2 No 1 ☐ Yes 2 X No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 P No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 Yes 2 No Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death. Funeral Director: A filled in by within 2 To the F

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) o rounar

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 8:56 June 28 P M Bobby Willis Segears, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Age (In yrs, last birthday) **Funeral** 1 XM 2 □ Months 4-9-1954 (Month 1954) Washington, DC Director 577-70-5549 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at by Funeral Director 1 Yes 2 ☐ No Washington DC 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code United States 20018 3023 Adams Street NE permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic. event the Mental Indian or other traumatic. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Book Binder Private 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Cora Long Benjamin Segears (wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3023 Adams Street NE Washington, DC 20018 Matilda A. Washington-Segears 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 7/6/2012 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, MD 20722 3401 Bladensburg Road Ruha Thompso 23a. Part 1. Ent. the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated event) Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No မြ 1 Tes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manne of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; Ai
completed filled in by the fu Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0057632 exE. while

State Registrar

31. Date filed (Month, Day, Year)

mtoteu, MD 11711 LIUINGSTON

nth, Day, Year) / 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

RD. FORT WASHINGTON, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Inpatient Care Center Harwood Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Hours 013-24-8489 Director 1 M 2 X F 80 1931 uly. 26 Massachusetts Usual Residence of Decedent 28a-f show . Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hart: If item 27 is marked of other than "natural", or Items 23a or 28a-f shoulary or other treumatic event, it. Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 84 North Old Mill Bottom Rd. 21409 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Secretary State of Delaware æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Archibald Irwin Beatrice Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan A. Slocum(Son) 7166 Lauren Lane Apt 1201 Easton, Md. 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 e
Department of H
Important: If ite
any injury or ot 1 Burial 2 Commation 3 Removal from State 7-5-12 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Windlame Reaches of Mail ons Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in doubly Last. Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

"To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No MANDRIN Other: 4 Nursing Home 5 Residence <u>유</u> 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 6 20 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene

State Amend#20B, per FH, QACHD, MS, 7/11/12
Certificate of Death

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 2012 JAMES D. SPEIGHTS, SR. 9:30 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Genesis HealthCare-The Pines Easton If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Hours Months Days 0670671927 85 MARYLAND Director 220-20-1364 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No TALBOT EASTON 10f. Zip Code 0e. Street and Number 10g. Citizen of What Country? Funeral 29374 WILL STREET 21601 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No 1945—
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates 1947 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) BAKER FOOD Be James Spe Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be Health and Ment JOHN T. SPEIGHTS, SR. CATHERINE BAPISTELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. DARLEEN GROVE / DAUGHTER 29374 WILL STREET, EASTON, MD 21601 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
WOODLAWN HEMORIAN
SPRING PARK HILL CEMETERY 07/12/2012 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EASTON. MD Name and Address of Facility
LLOWS, HELFENBEIN & NEWNAM FUNERAL
6 SHAMROCK ROAD, CHESTER, MD 21619 21. Signature of Funeral Service Licensee HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Serile dementa disease or condition resulting in death) Hvanced gravs Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter University
Cause (Disease or iinjury Due to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHF, Sick Sinus 1 Yes 2 No 3 Probably 4 Unknown Completed +100, PVD, Chroniz 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Kidney 2 No distase 1 Yes 25. Was cas ferred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 2 L No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 1 Natural 5 Pending Accident s after death.

I Director: Af 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

U+ | State

DHMH 17 Rev 7/2009

Registrar

6101

egistrar's Signature

Faston MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4	For State Registrar	State of	iviaiyldi				Death			Reg. N	401	2 20	366
Physicia		1. Decedent's Name (First, Middle, Las.								. Date of D _Month		ay Year	3. Time o	
/Medic	al .	MARY LOU SEWELI								JULY	0:			7 '
Examin	er	4a. Facility Name (If not institution, give	. 1	ber)		4b. City	ast a	or Location of	Death		40	C. County of Dea	1	
		Memorial Hos 5. Social Security Number 6. Se	pital	7. Age (In yrs.	last birthday)	If Unde	er 1 Year	II Under 2	4 Hrs. 8	. Date of B	irth		thplace (State ountry)	or Foreig
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퍽	1	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside C	ity Limit
other traumetic event, the Mudical Exeminar must be notified at	ģ	MD TALBOT			EAS	TON							1 X Yes	2 🗆 N
000	Funeral Director	10e. Street and Number				10f. Z	ip Code				10g. C	itizen of What Co	ountry?	
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	nue	11. Marital Status	12. Was Deced Armed For	ces?	I.S. 13.	Was Deci	edent of I ecify Cub	Hispanic Orig an, Mexican,	in? (Speci Puerto Ri	fy Yes or N can, etc.)	lo-	14. Race - Ame Black, Whi		
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	Be (17. Father's Name (First, Middle, Last)						18. Mother	's Name (First, Middl	e, Maide	n Sumame)		
	2	HARRY E. BRYAN						OLIV	VE MA	Y EVA	NS			
		19a. Informant's Name/Relationship (7									_	or Town, State,		
		PHYLLIS PERKINS /	DAUGHT		_				D., C		-	E, MD 2		
		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from S	late (Place of Dispo cemetery, cre			1				Location - City or		
		4 □Donation 5 □Other (Specify		ST							_	VENSVIL		
once.	1	21. Signature of Funeral Service Licen	-Van	1		06 SE	IAMRO	CK ROA	AD, C	HESTE	R, M	FUNERAL D 21619	HOME,	P.A
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that ca	used the dea ich line.	th. Do not en	ter the mo	ode of dy	ng, such as o	cardiac or i	respiratory	arrest,		Approxima Interval Be	etween
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	Examiner	that initiated events resulting in death) Last	U	ae mi		0,70	<u> </u>	11190	fu					
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	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								Ì	23d. Date of de	slivery	
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	by P	Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the u	inderlying	cause gi	ven in Part I.		23e. Did	tobacco	use contribute t	to the cause of	death?
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paña e sucono na data	Completed									24a. Ws	is an	24b. Were a	utopsy finding	s availab
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		27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date o (Monti	f Injury h, Day Year)	28b. Time o Injury	of	28c. Inju	iry at ork?	j	d. Describe	e how inj	ury occurred		
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	Mec	29b. Signature and title of certifier	andmann	er stated.		2	9c. Licen	se number			29d. D	ate signed (Mor	nth, Day, Year)	
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- 1		30. Name and address of person who on RAVI MOHAN, MD			INGTON		mm	EVCHO	л мт	2160	1			
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DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Antonio Bravo Torres 2012 2004 JIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cheverly **Examiner** 4c. County of Death Prince George's Prince George's Medical Center Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days none 55 7/9/7/956 Mexico Director 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director St.Mary's MD Charlotte Hall event, the Medical Examiner must be notified 1 🗆 Yes 2 🏲 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 30394 White Drive 20622 Mexico "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Mexican White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Busboy Restaurant other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Antonio Bravo Genoveva Torres Villagran wife 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. 4, Milpas 310, Santa Ana, Guanajuato, Mex. item 27 Esperanza Hernandez Mendez permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20c. Location - City or Town, State
Santa Ana
Guanajuato, Mexico 20b. Place of Disposition (Name of Date cemeter, crematory or other place) Cemeterio de Santa Ana 1X Burial 2 ☐ Cremation 3 X Removal from State 7/16/2012 5 Other (Specify) 4 Donation PHYMERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of physician and s the burial-rapsit Exami requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant g ☐ Unknown Pregnant at time of death igned by the at be detached for 1 Yes 2 Dunknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 2 🗌 No Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred / 28c. Injury at Certificate: 1 Natural
2 Accident 5 Pending s after death. 1 Yes 2 No)UNE 23,2016 Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Nun City or Town, State) filled in by determined STREET harlotte ita Medical Mal 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature/and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#1perMD, 7/12/12; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Adalberto Merenciano Herrera Tapia 2. Date of Death Physician/ erre Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4207 Largo Road Upper Marlboro Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 5/21/1970 218-55-7183 42 Mexico Director 1 🖾 M 2 🗆 F r than "natural", or items 23a or 28a-f show the Wedcal Examiner must be notified at filed within 72 hours efter death with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George' MD Upper Marlboro 1 🗆 Yes 2 🖺 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4207 Largo Road 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 □ No Specify: Mexican Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental h Evangelina Tapia Mendez Filemon Herrera Carino should be if, Page 1 and 2 shou...
If Page 1 and 2 shou...
If I health and Me
I 2 in mr
I 3 in mr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) Irma Luis Sanchez/Wife 4207 Largo Road Upper Marlboro, Maryland Baltimore, t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
San Islano Jehuital, Guadalupe, Santa Ana, Puebla, Mex 1X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department Importent: If any injury or 7/14/2012 4 Donation 5 Other (Specify PHNaher Addes RANALDI FUNERAL SERVICE, P. A (Funeral Serv . Signat 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician, ANCER Innet and Beath NENDWN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine One to for as a nonsequence off To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours efter death.

To the Funerei Director: After this certificate has been signed by the "ttending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-law at that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Bax 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 🗌 No 1 Tes Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2/ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tifle of certifie ho completed cause of death (Item 23a) (Tv State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1635 WILLIAM WHITMAN TRIPLETT M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5223 LONG PT. FARM DR. OXFORD TALBOT Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) 238-80-6049 Director 1**X** M 2 □ F 52 09/02/1959 NORTH CAROLINA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5223 LONG PT. FARM DR. 21654 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 🗌 Widowed 4 🗌 Divorced If Yes, Give Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry MPPETT, William (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 **−**∩− **PARTNER** INVESTMENTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ROGER B. TRIPLETT ELIZABETH COPENHAVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARKE C. TRIPLETT/BROTHER 2560 SOUTH SHORE DRIVE S.E. ST. PETERSBURG, FL 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARE OCREMATION CENTER 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 06/29/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses FECTOWS Address FETT & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1/4WO 1K/OTiC disease or condition VILL Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 ate has been signed by the attending p page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No q 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performe this certificate has prior to completion of cause of death? 1 Yes after death.

Director: After this certific 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗹 No 1 🔲 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М 2 Accident Investigation To the Hospital or Atte within 24 hours after der To the Funeral Director completely filled in by the 3 ☐ Suicide 4 ☐ Hornicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 125 completed cause of death (Item 23a) (Type, Print) Vnwood Dr. Faston, MD 2160 31. Date filed (Month, Day, Year) State JUL U 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jane Physician/ 2012 Michael Ray Taylor 451 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Cambride Genera Dorchest Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. (Month Day, Year) 58 Country) 54 Ohio 213-70-7762 May Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Hurlock 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6203 Mission Hill Road 21643 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiere.

Department of Health and Mental Hygiere.

Important: If item 27 is married other than "
any injury or other traumati" event, the Mee life. DO NOT use retired)

maintenance Elementary/Seconday (0-12) College (1-4 or 5+) rendering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Norman Ray Taylor Nina J. Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda R. Cowgill daughter 6219 Mission Hill Road, Hurlock, MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State Crematory of Delmarva 7/6/12 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a c Examir attending physician and for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital 2 **X** No Other: 1 Tyes <u>ا</u> 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Ahm 2012 65528 pleted cause of death (Item 23a) (Type, Print) Ahmed 1 300

DHMH 17 Rev 7/2009

State Registrar 31, Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ ALLEN H. VALLIANT 8 2012 PM 9:10 Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare-The Easton Pines g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 1 X M 2 □ F Days Hours 08/17/1917 94 MARYTAND Director 218-01-8054 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 610 DUTCHMAN'S LN. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mentral Hygiene. Important I filem 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Yes 2 □ No
Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) FURNITURE SALESMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MINNIE E. MORRIS ALLEN H. VALLIANT 19a. Informant's Name/Relationship (PAPRECONAL) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 BROOKLETTS AVE. EASTON, MD 21601 BRUCE D. DUNCAN/ REPRESENTATIVE Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of CHds:5AcRt:Akaton GREMA/EJON 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/29/2012 STEVENSVILLE, MD CENTER FENDOWSADDHELLEENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause of each Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Toures disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed favanced sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ My partingion, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 No Yes 2 INO To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 12 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ۵ R162359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

610 Dutchmans Ln.

Gaston MD 2160

DeFiglia

JUL 0 2 2012

FNP-BC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Frances Viola Waltz 7:30 p м June 28 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster 91 Pennsylvania Avenue . Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, Year) Hours **Director** 217-50-6466 64 Oct 29, 1947 Pennsylvania 28a-f show 10d. Inside City Limits äţ 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 No Maryland Carroll Westminster ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 91 Pennsylvania Ave 21157 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married "natural", or þ Yes 2 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. white Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Rehabilitation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Center Secretary other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Geneva Gladys Waltz unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3418 Old Hanover Road, Westminster, MD 21158 Geneva Hugg, sister Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ceme Sopping atory or other place) 20c. Location - City or Town, State o permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2012 Winfield, MD Carroll Crematory Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Street, Westminster, MD 21157 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a nonsequence of) if any, leading to immedicause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of): nding physiciar Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 5 Other (specify) the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner? Hospital: 2 No မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury ours after death.

Interest of the formula of the f Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Person J. MD

DHMH 17 Rev 06-2011

Registrar

Registrar's Signatur

DHMH 17 Rev 06-2011

Registrar

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Box 68760

P.O.

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		For State Registrar	State of Maryl		rtificate of			gierie Reg. No.	2012	2 23670			
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	0	PENINSULA REGIONAL	of adject	Center	5	46/36414	Table (B)		KIDOM				
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Maryland 28a-f shov atified at	Director	10a. State 10b. County VA Accom	1	. City, Town or L	ocation	Parksley				10d. Inside City Limits 1 Yes 2 No			
ith the	ral D	10e. Street and Number 24092 Adelaide St.,			10f. Zip Code	23421		10g. Citiz	en of What Cou US				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		. Was Decedent Ever in Armed Forces?	n U.S. 13.	If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-		4. Race - Amer Black, White	ican Indian, , etc.			
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Page 1 ar ment of Hk ant: If iter ury or oth		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Re 4 🗆 Donation 5 🗀 Other (Specify)	moval from State		osition (Name of ematory or other pla Baptist Cen		Date 7/2012	20c. Loc	Bloxor				
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Medical Examiner		disease or condition resulting in death)	Due to (or as a con	sequence of):	1001ty	CRIVIX							
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Physi r this c eral dire	Hospital: 1 Wes 2 No No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing No 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at							dence 6	Other (Speci	fy)			
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To t with To t		29b. Signature and title of certifier	MA		29c. Licen	se number 4997		29d. Date	7-03	Day, Year) - 2012			
771		30. Name and address of person who com		(Item 23a) (Type,	Print) 100 É. CA	rroll st.	5/1/5	BUN	MO				
Stat Registra		31. Date filed (Month, Day, Year) 9 20	32. Rigistrar's Si	ignature	barker	t the time, date and pose number 8997 7001 54			(-				

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Carole Ann Wood 07 2012 8:27 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 9527 Springhill Newtown Road La Plata Charles Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours **Director** 220-38-3531 1 □ M 2 👿 F 69 11-28-1942 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland | Charles La Plata 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9527 Springhill Newtown Road 20646 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ģ 1 Never Married 2X Married Maryland 21215-0036 72 hours after 1 Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Charles County Department of Health 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard R. Clark Lillian A. Bowdish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau William E. Wood/Husband 9527 Springhill Newtown Road La Plata, MD 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 07-11-2012 | La Plata, Maryland Wesleyan Memorial 21. Signature of Funeral Service Licen 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A Variel M01458 211 St. Mary's Ave. La Plata, Maryland 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Such Sha Physician/ shock disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialng physician as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive pulmonary 2 No 3 Probably 4 Unknown Intristitues 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 Residence 6 \(\text{Other (Specify)} \) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending ours after death.

neral Director: Af
filled in by the fu 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0033426

State Registrar 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month JUL Year) 9 2012

back

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For		State of M	larylan		partment of H		/lental Hy	/gien	e 20	12	23672
	_	State Registrar				Ce	ertificate of L	Death		Reg. N	o. C U	1 4	20076
Physicia	n/	1. Decedent's Name	e (First, Middle, La	STI STI					2. Date of D Month		ay Y	ear 2	3. Time of Death
Medic		4a. Facility Name (if	not institution, give	e street and number)			4h City Town o	r Location of Death			c. County of		2340 M
Examin	er	C	MH	3 30 30 t al 12 mail 30.7			Per De	PRE JORI	(8)	4	Cal		it
Funeral		5. Social Security N		Sex 7. Ag	ge (In yrs. Ia	ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi		9		lace (State or Foreign
Director		578-46-0		XM 2□F	7	Yrs.	IVIONI(II)	Tiodis IVIII.	03-08-		_		., D.C.
and show at	or	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation.		00 00		- 1"		0d. Inside City Limits
Maryla 18a-f	rect	MD	Calver	t			Prince I	Erederick					1 ☐ Yes 2 🔀 No
a or 2	i D	10e. Street and Nur					10f. Zip Code			10g. C	itizen of Wha	at Coun	try?
th with ms 23 must	Funeral Director		nutt Ct.,	Apt. 312			2067				USA		
r deat or iter niner	by Fu	11. Marital Status	ried 2 Married	12. Was Decedent Armed Forces? 1 X Yes 2	Ever in U.S	3. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black,	America White, e	
s afte ral", c Exan		3 Widowed		If Yes, Give Year or Dates.		-58	1 ☐ Yes 2 💢 No	Specify:			Specify: [Whit	e
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l be fil lental rked tic ev	ı٥		Luke Wal	ker				Rose Ida			· Garriario)		
should and N is ma		19a. Informant's Na				19b. Ma	ling Address (Street				or Town, Stat	e, Zip C	ode)
nd 2 s ealth m 27				d, daught	er	16	Hampton Ro	d., Linth	icum He	eight	ts, MD	21	1090
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			X Cremation 3	Removal from State	, c	emetery, cr	position (Name of ematory or other plac	ce)	Date		Location - Ci	•	
artmer artmer ortant injury		4 Donation 21. Signature of Full	5 Other (Special Lines		Met	ropo]	itan Crem	atory 7/9	9/2012	A1	exandı	<u>:ia,</u>	VA
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Physician/		Immediate Cause ((Final	Met	a 5.	tati	ic Squar	1045 Cell	Cancer	- of	Peni.	5	Unset and Death
Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ience of):	E				, 4,11		9
	er	Sequentially list co	enditions,	b. — Due to (or as	a consequ	ience of						+	
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executed ian and urial-transit	Ex	that initiated events resulting in death) I		C. Due to (or as	a consequ	ience of):							
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ath ce attenc for us	cian	23b. Was decedent in the past 12	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	Ideath 3	☐ Ectopic pregnand ☐ Other (specify)	су			23d. Date of Month		ry Day Year
he de y the ached	hysi	1 Yes 2 Unknown		9 🗌 Unknown	at time or c			-					
that i		Part II. Other signif	ficant conditions of	contributing to death	out not res	ulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco	use contribu	te to the	e cause of death?
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or Atte fter de irecto n by ti	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined				treet, factory, office		28f. Location (City or To			r Rural I	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu		20- 0-49 1	Contifuing Div	rations. To all a least a					-				_
e Hos 24 hc e Fun e Fun letely	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical Exam	rsician: To the best of tiner: On the basis of the se Practitioner: To the	examination	and/or inve	estigation, in my opinio	on, death occurred at	the time, date	and plac	e, and due to	the cau	se(s) and manner stated.
To the within To the Comp	2		title of certifier	se Practificing 1. 10 (le gest of th	/ KypWigag	29c. License		ace, and due to		ate signed (N		
		- VIA	was h	11. Qu	und	19 M	w DO	0524	01	Ju	lu s	7	2012
W	-	30. Name and addre	ess of person who	completed cause of c	leath (Item	23a) (Type,	Print)	١٠١٠ (J.,	7 1	D ANIMA
7+1		31. Date filed (Month	h, Day, Yearl	32. Regist	as Signat	1705	PITAL K	Day Pr	incel	rtd	erick	, /V	M 400.18
Stat Registra			JUL -	9 2h12	5 Signat	.ui e	1.	. /				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Delath 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham 6307 Martins Lane Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Q1Q Days Hours Min. Country) West 212-98-3486 93 Director 1 M 2 D 11 Jamaica, Indies February 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1X Yes 2 No Maryland **Prince Georges** Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20706 6307 Martins Lane Jamaica,West Indies 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. ò à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Black "natural" 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Engineer Domestic 8th grade other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) snould be file th and Mental H ဥ McPherson Jacob Ricketts Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gloria Leantie Smith (Daughter) 6307 Martins Lane; Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) July 13,2012 Manchester, Jamaica, 20a, Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Ketts-Wint Family Cemetery 4 Donation 5 Other (Specify) West Indies Signature of Funeral Sealc 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 M01421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) law requires that the death certificete be executed Jause (Disease or mjury burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No the a detached 9 X Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bliknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 autopsy Hospital or Attending Physicien: The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 To the l within 2 To the l only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) Name and address of po JUL 0 9 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wilson 367a Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TAlbot EASTON EASTON Hospital Menorial If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-24-586 1 □ M 2 🗷 F Director Maryland Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No -aston Tal filed within 72 hours after death with the 10g Citizen of What Country? 10e Street and Number **Funeral** 2160 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Black 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event" (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ည 1:150n 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or tella 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pa een Esther Cemetery Easton, Mary 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Itome, uneral Washington St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -126 .Pnysician/ er 6 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ending physician a use as the burial-Physician/Medical Records, P.O. Box 68760 signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes After this certificate has been sifuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Department 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29c. License number 1) ØØ65656 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) CRO South Enstun 219 31. Date filed (Month, Day, Year) Registrar's Signature State 0 5 2012 Registrar

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Wilson

			For State		State of	Marylar					and N	/lental Hy	giene	201	2 2	267
			Registrar 1. Decedent's Na	ma (First Middle	(act)		Cer	tificate	e of D	eatn			Reg. No	. 201		367
	Physicia	in/	Denby	smith	Zimmerma	n						2. Date of De Month July 9		012 Yea	r	of Death
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	Examir	er			iens at Rid		V411.			Location			40	. County of De	eath	
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	or 28a notif	Director	MD 10e. Street and N	<u>M</u> o	ontgomery		Silve	er Sp					10. 0			res 2 XNo
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ဖွ	ter de , or it	by F	1 Never Ma	arried 2 Marr		es? 2 🔀 No	li li	Yes, spec	ify Cubar	n, Mexicar	, Puerto	Rican, etc.)		Black, WI	nite, etc.	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Di				Place of Dispos cemetery, crem	sition (Nam	ne of	- :					or Town, State	
Ĕ	Page nent ant: Il			2 🔼 Cremation on 5 ☐ Other (S	3 ☐ Removal from Specify)		ropoli				20	y 9, 12	Ale	xandria	a. VA	
alt	permit. Departr Imports any inju		21. Signature of	aneral Service L	e e e e e e e e e e e e e e e e e e e						ins	Funeral				
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0	cling Phy th. After thi funeral	cate	1 Natural 2 Accident	5 Pendin	g (Month,	Day, Year)	injury	M 20	Bc. Injury work?		- 1	28d. Describe h	ow injury	occurred /		
210	of or Attendate af er death Director: A	Certificate:	3 Suicide 4 Homicide	6 Could r	not be	f Injury - At ho	me, farm, stre			- 2	-	28f. Location (S	Street and	d Number or F	Rural Route Nur	nher
Division of	alor.		4 🗆 Homicide	determi		, etc. (Specify						City or Tow				
	To the Hospital or Attenting Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier	1 Certifying	Physician: To the bes	t of my knowl	ledge, death o	ccurred at	the time,	date and	place, ar	nd due to the ca	ause(s) ar	nd manner as	stated.	
	the Hi iin 24 ine Fu the Fu	Med	only one)	3 LX Certifying	xaminer: On the basis Nurse Practitioner: T	of examination the best of n	n and/or investi ny knowledge,	gation, in m death occu	ry opinion rred at the	n, death oc e time, dat	curred at te and pla	the time, date a ce, and due to t	nd place, he cause	and due to the (s) and manner	e cause(s) and n as stated.	nanner stated.
	Veitt		29b. Signature and	d title of certifier	. /(\ \	O 29c.	License	number			29d. Dat	e signed (Mor	oth, Day, Year)	
	20			way	e Ha	de	TIM	16	112	63	3		-	1/9/1	2	
			30. Name and add	fress of person v Hardin	who completed cause CRNP	of death (Item	(23a) Type, Pi Gracef	int)	Road	, S1	lver	Spring	, MD	20904		
	Ch-		31. Date filed (Mor													
	Stat Registra		J. Duto mod mon	UL 10 2	2012	istrar s Signar	re for	Kal	1							

DHMH 17 Rev 06-2011

OR ORNE (Charlott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY PAMELA JEAN ZACEK 3:53 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 108 CHESTNUT ROAD STEVENSVILLE OUEEN ANNE'S Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours **Director** 018-34-7631 1 □ M 2 🕱 F 67 Usual Residence of Deced MASSACHUSETTS 01/08/1945 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** notified QUEEN ANNE'S 1 Yes 2 X No STEVENSVILLE 10e. Street and Numbe ō 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? 108 CHESTNUT ROAD <u> 21666</u> UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 X Divorced "natural" Completed Specify: WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the HEALTH CARE HOME HEALTH AIDE other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည IRA JAMES PURDY VIVIAN ELLA MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA WHALEN / NIECE 108 CHESTNUT RD. STEVENSVILLE, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION
CENTER 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 07/07/2012 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
106 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi): use as the burial-tran and Due to (or as a consequence of): nding physician Physician/Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy e Hospital or Attending Physician: The I 124 hours after death. e Funeral Director: After this certificate h performed 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of certifier

Normal Wulse M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Queenstown MD 21658

State Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:55 PM M 24 June Scott T. Angus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg 202 Park Avenue #308 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) **Director** 274-58-0556 1 XM 2 □ F 52 Yrs. Jan 31. Ohio Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10d. Inside City Limits 10a. State 10c. City. Town or Location Director MD Gaithersburg 1 Yes 2 X No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20877 202 Park Aenue #308 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) manufactoring salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Angus Mary Frances Teeters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Todd Angus - brother 343 Cedar St NW #304; Washington, DC 20012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Wother (Specify) in Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that a used the leath. Do not shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai Due to (or as a obj attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) been signed by the sahould be detached contributing to death but not resulting in the underlying cause given in Part I. contribute to the cause of death? 23e. Did tobacco usa ģ 2 No 3 Probably 4 Unknown Be Completed 246. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy director, page 2 certificate Yes 2 25. Was case re 26. Place of Death (Check only one) examiner? Hospital Other 2 27. Ma Medical Certificate: 1 🛚 3 [

Hospital or Attending Physician: The law requires that the death certificate be executed filled in by the funeral 24 hours after deat Funeral Director: completely within 2

2

1 169 2 NO	1 Inpatient 2 I	ER/Outpatient 3 L	DOA 4 Nursing H	ome 5 Nesidence 6 Other (Specify)
nner of Death Natural 5 Pending Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred
Suicide 6 Could not be Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Check , 2 Medical Examiner	r: On the basis of examination	d/or investigation,	in my opinion, death occurred a	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated. lace, and due to the cause(s) and manner as stated.
gnature and title of certifier		2	9c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26

State

Registrar

29a. C

29b. Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Canterbury House Assisted Living Prince George's Temple Hills If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Hours 92 8/2/1919 579-01-9566 Virginia Director 1 M 2 1 F Yrs Usual Residence of Deceder or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's Camp Springs MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20746 Funeral 5304 Manchester Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Midowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event "to once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Jane Lee Arthur Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5304 Manchester Drive Camp Springs, MD 20746 Violet Garland/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harmony Memorial Park07/27/2012 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licer 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one caus ach line Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the signed by the attending a d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 4 Pregnant Pregnant at time of death 1 Yes 24 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown iis certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 24a. Was an autopsy After this certificate has e Hospital or Attending Physician: The I 24 hours after death. • Funeral Director: After this certificate h 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie ppleted cause of death (Item 23a) (Type, Print) Name and address of person who co ENEVIEUR OB

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 23679 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Awur Jomas 1450 ろいに Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Iniversity of Maryland Medical Cent Himore Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-94-0966 Hours **Director** 1 3km 2 0 F 63 06/07/1949 Cameroon Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location at 10d. Inside City Limits the Maryland Director must be notified MD Montgomery Co. Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Completed by Funeral 23a U.S.A. 20903 1815 Greenwick woods Apt 13 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ral", or iter Examiner Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify: Specify "natural", 3 Widowed 4 Divorced Year or Dates Ith and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Vears Fairmont Hotel Building Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Zacharia Awuro Debora Ado Awuro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 3563 Fortmeade Rd., Apt 223, Laurel, MD20724 Eddie Awuro(son) other. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. Awuro Family Cem. unk Camaroon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Form Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physics and)iffuse Alveolar Hemombag disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perforn To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Yes 2 X N 2 🗆 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Investigation the Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 [Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title

31. Date filed (Month, Day, Year)

10

Kokajko, M.D

2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene

Registrar's Signatu

29c. License number

102528

Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25, PER ME G929 7/25/12 TRT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY Jay 大 大 人 く し し え FRANCES BROOKS 11.12 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HUSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 215-56-8028 **Director** 1 □ M 2 🗹 62 and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-1 successive event, the Medical Examiner must be notified at 10a. State Town or Location Funeral Director 10d. Inside City Limits 1 Yes 2 No 21061 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed 3 Widowed 4 Divorced Blac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life IDO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Be Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 🛂 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si vaure of Fune al Service Ligensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the Approximate Interval Between shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Terine Ph_sician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam Year and that initiated events resulting in death) Last Physician/Medical Kid that the death certificate be attending i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ oronary Arters Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Kypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending iniury Division work?
1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours to the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBORHOSPITAL, BALTIMORE. M.D. RAGHURAM CHAVA 31. Date filed (Mont. State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

16a&b Per ANA BD G930 8/16/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 20PM EDWARD ARTHUR BULKELEY 0:71 4 7 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6000 SAMARITAN BALTIMORE MD HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Unk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Social Security Number **Funeral** Min. Months Davs Hours 65 Director 022-34-2322 1 XM 2 X 1946 July 23, Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County at 10a, State with the Maryland Director 1 Yes 2 □ No notified Baltimore MD 28a-f 10g. Citizen of What Country? 10f. Zip Code 21206 10e. Street and Number 능 be 6116 Bel Air Rd. 23a Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? **unk** 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status unk Black, White, e 1 Never Married 2 Married Completed by white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working 16b. Kind of Business/Industryunk 15. Decedent's Education (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 10 unle -unk- Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unle ပ Victorice Ruth Roger Bulkeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Adult Protective Services
300 Metro Plaza; Baltimore, MD 21215 19a. Informant's Name/Relationship (Type, Print) Oyelana Ayodapo - guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Difector Funeral Servi S. Wade 655 W. Baltimore St; Baltimore, MD 21201 22 Approximate Interval Between Onset and Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Hypoxic Durio ras a conse Dans Medical r as a consequence of) Examiner respiso Se uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic and that initiated events the burial-tra Due to (or as a consequence of): resulting in death) Last iding physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for u in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant at time of death the the 9 Unknown signed by t d be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ል 1 Yes 2 No Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 🗌 No after death.

Director: After this certificate 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital ြို 1 Yes No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 🗌 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Atle of certifier MD RES-000 7/17/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CIRAT TIMILSINA 5601 Loch Raven Bivd, Raitimore

Registrar DHMH 17 Rev 06-2011

State

TIMILIINA

2012

2 6

31. Date filed (Month, Day,

Registrar's Signature

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ivy Brandon 2012 7:36 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Hours (Month, Day, Year) **Director** 579-64-9461 63 1 M 2 X F Yrs Usual Residence of Decedent ?? Is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Marker Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location the Maryland 10d. Inside City Limits Directo MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 114 Elizabeth Avenue 21225 USA 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) Brandon 16b. Kind of Business/Industry Unit and Mental Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Elizabeth Ave; Baltimore, MD 21225 Leola Foster - caregiver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 5 cemetery, crematory or other place) 21. Signalure of Euroral Service Unensee
Ronald Wade, Wirector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Metastatic breast Medical resulting in death) Due to (or as a consequence of): Examiner metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform death? 1 ☐ Yes 2 🔊 No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R107529 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howe 301 Hospital Dr. GlenBurnie MD 21061 ACNP-BC

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 State of Maryland 2 Department of Health and Mental Hygiene 1 - State Registrar amend 7 per bc. g930 8/30/12/2 remeate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 18 2012 10:28AM BABY BOY BRENNAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAI FREDERICK FREDERICK 8 Date of Birth Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) **Director** 1 XM 2 □ F INFANT 6 July 18, 2012 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location at Completed by Funeral Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified i 1 Yes 2 X No Walkersville Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21793 267 Providence Circle filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12)
INFANT College (1-4 or 5+) INFANT INFANT Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ೨ Michaela Elizabeth Brennan . Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 400~7th~St;~Frederick,~MD~2170119a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Frederick Memorial Hospital Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X other (Specify) in state Ronald S 22. Name and Address of Facility State Anatomy Board Wade (Director 655 W. Baltimore St; Baltimore, MD 21201 yt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Perinatal AsphxiA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Respire ten Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last XTREEL Physician/Medical IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acidosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? POSIBL Seps 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Division of Vital Records,

within 24 hou

To the Fune

completely fi

Medical

4 Homicide

29a. Certifier

determined

6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0031315

28f. Location (Street and Number or Rural Route Number,

Frederick MD 21701

07-18-2012

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Marylar	nd / Department of	of Health and	Mental Hygiene

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Michael Forrest Bu	1	S State - For State Registrar	of Marylar		artment o ertificate o		nd Mental	Hygier		g No	20	12	236
Physician Medical Examine	7	1. Decedent's Name (First, Middle,Las Michael Forres		3	. , ,		_		te of Deat nth y 16, 20		Year	3. Time of 1400	
		4a. Facility Name (if not institution, given 504 Colleen Road Apt. F	e street and num	iber)		4b. City, Town, o Baltimore	r Location of D				ounty of Dea	ith	
Funeral Director	- 1	5. Social Security Number 6. S 214-58-5519	ex 7	7. Age (In yrs. 61	last birthday) Yrs	If Under 1 Yea Months Day				h(MM/DD		Birthplace (StateignMary Country)	
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ith the Maryland 23a or 28a-f show notified at once.	Juector	10e. Street and Number 504 Colleen Ro	24 F	Dai	cimore	10f. Zip Code 21229					of What Co		2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director	5	11. Marital Status 1 \(\overline{\	12. Was Dece	ces?		as Decedent of Hi es, specify Cuba			es or No-	JSA 14.	. Race - Ame White, etc.	erican Indian,	Black,
ours after d atural", or aminer m	<u> </u>	3 Widowed 4 Divorced	1 Yes If Yes, Give Year or Dates; nly highest grade	2 X No completed)		it's Usual Occupa	ition (Give kind		ne		ecify: Wh		
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exar	analdille	12th grade	College (1-4	1 or 5+)	Labor	ost of working life	e. DO NOT use	retired)		Bali	timor	e Cit	У
21215-0036 lid be filed within 7 Mental Hygiene. event, the Medical context of the Medical	å L	17. Father's Name (First, Middle, Last George E. Burns 19a. Informant's Name/Relationship (1			10h Mailin	Addrona (O	18.Mother's N	Fuch	s				
and 2 should and 2 should fealth and Me item 27 is matter or traumatic or	L	Melissa Burns/ 20a Method of Disposition	Sister	20b.	aw 476	ition (Name of ce	Iris	Dr . My	yrtl	e Be	each	S.C.2 or Town, State	9577
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other ir		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service Licer				Cremat	-0 - 1			Dund	dalk,	Maryl	and
Physician		23a. Part I. Enter the disease, or comp	lications that cau	ised the death	5.	lame and Addres 240 Rei	sters such as cardi	natma cown	an – H Rd •	arri Balt est, shock,	s fu imor		Home 21215
/Medical xaminer			ach line. Hyperten Due to (or as a c			scular I)isease						Onset and eath
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68760, certificate be ex nding physician se as the burial -		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, ou	tcome of preg		r me,g93		_	n ———	23d. D	ate of delive	ry	
). Box 6876(the death certificate by the attending physiched for use as the b Physician/Me		past 12 months?		nt at time of de	noth _	tal death 3 ner (Specify)	Ectopic pre	gnancy		Mo	onth	Day	Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Extension								- _	la. Was a autops perforr ✓ Yes 2	ned?	prior to death?		f cause of
/ital R /sician: T mis certifice director, ps		5. Was case referred to medical examiner?	lospital: 1 Inc	patient 2	ER/Outpatient		of Death (Che		e)		1 🗸 Y		No
Division of Vital I Division of Vital I to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director. edical Certification: To Be (7. Manner of Death 1 X Natural 5 Pending	28a. Date of (Month, D		28b. Time of I	njury 28c Inju	ry at Work?			ow injury o		ei. Ocene	
Division o optial or Attending hours after death. uneral Director: Aft. y filled in by the func. Certification:		2 Accident Investigation 3 Suicide 6 Could not determined	28e. Place o	of Injury - At h	ome, farm, stree	t, factory, office b	ouilding, etc.		cation (St Town, St		Number or R	ural Route N	ımber, City
To the Host within 24 hc To the Fun completely		9a. Certifier 1 Certifying Physici Check only 2 Medical Examiner	an: To the best of the basis of and manner state	examination a	lge, death occur and/or investigat	red at the time, dation, in my opinion	ate and place,	and due to te	the cause ne, date a	e(s) and m ind place,	anner as sta and due to t	ited. he cause(s)	
	2	9b. Signature and title of certifier			N	99c. Licens O.C.					e signed <i>(Ma</i> 7, 2012	onth, Day, Yea	r)
0x bero			Assistant Me	dical Exan	niner 900	W. Baltimore	Street, Bal	timore, N	MD 212	23			
State Registral		1. Date filed (Month, Day, Year)	32. Aegr	strar's Signatu	1 pas								
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 C. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 20 hours after death.

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		For State Registrar			waryiand		artment of F tificate of L			F	Reg. No.	201	2 2368	86
Physicia Medic		1. Decedent's Name Doris N	eale B	usby						2. Date of Dea Month July	Day 24,	2012	3. Time of Death 2 12:04 P	
Examin	er	4a. Facility Name (if 21 Maryl		give street and numb	er)		4b. City, Town, or Gaithe					unty of Deal		
Funeral Director		5. Social Security N 224–64–2	umber (. Age (In yrs. las		If Under 1 Year Months Days	If Under 2 Hours		8. Date of Birth (Month, Day	1	9. Bir	thplace (State or Foreig untry)	gn
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3a-f sh lified a	Director	MD		omery	Tuc. City,	Town or Lo	Gaither	shura					10d. Inside City Limit 1 X Yes 2 1	
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ems 23 r must	Funeral	21 Maryl	and Ave	nue	ent Ever in U.S.	13. \	208 Vas Decedent of Hi		in? (Speci	fv Yes or No-		ed Sta	rican Indian,	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marr		Armed Forc	es?	ŀ	f Yes, specify Cuba	n, Mexican,	Puerto Ri	can, etc.)		Black, Whit		
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I Hygie other vent, tl	Be	17. Father's Name (First, Middle, La	1 4 st)		Reg1:	stered Nu		r's Name (First, Middle, I			Le	
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Impo any once		Deve	ely L	Halte	MO1	251 B	oing Home everly L.	Crem Heck	ation rotte	n Servi e, P.A.	ce P. Clar	O. Bo: ksvil	x 784 le, MD 2102	29
ysician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List on Final	omplications that carly one cause on each	n line.	ement		g, such as c	ardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death Years	
taminer transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):													
physician and the burial-tra	ledical Exa	that initiated events resulting in death) I		c. Due to (or	r as a conseque	a consequence of):								
Think 24 hours are death. To the Funds are death. To the Funds are death. Completely filled in by the funeral director, page 2 should be detached for use as the burial-	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ∑ 9 ☐ Unknown	months? ☑ No		rth 2 Fetal ant at time of de	death 3	Ectopic pregnand Other (specify)	ey .			23d	l. Date of de Mo <i>n</i> th	livery Day Year	
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tor: Aft tor: Aft the fur	ertificate:	1 X Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendi <i>n</i> g Investiga 6 ☐ Could n	ation of he				Yes 2 🗆 I	-					
al Director al Dir	o l									ral Houte Number,				
n 24 nou te Funer pletely fil	Medica	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st 3 Certifying Nurse Practitioner:										cause(s) and manner sta	ated.	
To th		29b. Signature and	file of certifier	ranga	\sim		29c. License	number		2		igned (Mont		
1			ess of person w	no completed cause			rint)							
,		Shyamsur	ndar Raj	ian 9801	Georgia	. Ave	Ste. 117	Silv	er S	pring,	MD 20	902		

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

JUL 2 6 2012

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23c, 25, 27, 28a-f per fh g931 9-6-12 vt. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 11:20 PM J. Fredric Buch Tul Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner aurel Regional Hospita Prince George's Laure Social Security Number If Under 1 Year If Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 093-16-6362 Hours 1 🛛 M 2 □ F Director 91 June 23.1921 Germanu show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Prince George's Silver Spring 1 Yes 2 No o 10e. Street and Number 10g. Citizen of What Country? Funeral 3148 Gracefield Road. 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married should be filed within 72 hours after or and Mental Hygiene. is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WWII Year or Dates. White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sally Buch Babette Weinmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara D. Buch - Daughter 1222 Downs Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 07/18/2012 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 123 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final Onset and Death Severe Sepsis Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying CERTIFICATION REPROTED BY Cause (Disease or injury that initiated events Hip Fracture Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires

 Were autopsy findings available prior to completion of cause of autopsy

Yes

25. Was case referred to medical examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 2 X Accident injury 5 Pending 7-10-12 unknown M Investigation 6 Could not be Suicide 4 Homicide

determined

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred subject tripped on wrought iron chair & fell

Dusen

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3148 Gracefield Rd. Silver Spring, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Senoir Living Community

7300

Laurel

Van

26. Place of Death (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other:

1 ☐ Yes 2 X No

28c. Injury at work?

2012

death?

2 🗆 No

Saritha Gorantla MD Laurel Regional

Hospital

State Registrar

Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20B, PERFH, G930, 8730/2012, WS
State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G935 1/28/2013 H

Certificate of Death Reg. No. 2012 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Alfred L. Bisnett 2012 10:28a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville 807 Maple Avenue Social Security Number 898 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 087-14-1 X M 2 □ F Director 89 12/22/1922 New York show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 28a-f Rockville 1X Yes 2 ☐ No Maryland Montgomery 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20850 807 Maple Avenue permit. Page 1 and 2 should be filed within 72 hours after death ¹ Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1942 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced 1968 White Year or Dates 16b. Kind of Business/Industry
National Institutes 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) of Health Administrative Employee Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Edna LaBarge Joseph Bisnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 807 Maple Avenue, Rockville, Maryland 20850 Richard E. Bisnett - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 28 2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia Arlington Natl. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service Licensee all 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ <u>Dementia</u> Medical resulting in death) Due to (or as a consequence of) **Examiner** Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) iding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 🛛 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner?
1 Yes 2 XNo Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of Il Director: After the 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IM Clinic, WRNMMC, 8901 Wisconsin Ave 31. Date filed (Month, Day, Year) State Registrar

C DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July $\overset{\text{Day}}{2}\underline{012}$ 20 \mathbf{P}^{M} Mary Patterson Bell 5:30 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1870 Quebec Street Severn 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) **Director** 131-30-0391 1 □ M 2 🛛 F Yrs 72 July 21, 1939 Usual Residence of Decedent New York or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 1870 Quebec Street 21144 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. William J. Patterson Christine H. Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Bell / Husband 1870 Quebec Street Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ly 23, 2012 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🗓 Cremation 3 🗀 Removal from State July 4 Donation 5 Other (Specify) Arundel Crematory Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 1411 Annapolis Road Odenton, Maryland 21113 Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ Coronary disease or condition years Medical resulting in death) Due to (or as a conse ince of) Examiner 100 Sequentially list conditions Examine Due to (or as consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, nours after death.

neral Director; After this

filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 X Natural 5 🗀 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 **Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) K118354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mon

7900

K-Point Ct Pasadena

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 10f, 18 per fh, 930 8-3-12 sm
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		-	For State Of IV State Registrar	raryiand 7Depa <i>Cei</i>	artment of F tificate of E			Reg. No.	2017	2 23690
	sicia		1. Decedent's Name (First, Middle, Last) Denise Helen Meier	Brennan			2. Date of De July	ath 2 ^{Day} ,	Ž ^e a ^r 1	3. Time of Death 2 5:35 AM
	ledica amine		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. C	ounty of Deatl	h
مہر			9104 Kirkdale Road 5. Social Security Number 6. Sex 7. Ac	ge (In up lost hirthday)	Bet If Under 1 Year	thesda If Under 24 Hrs.	8. Date of Bir		Montgo	
Fun Dire			384-20-4532 1 \(\triangle \text{M} \) 2\(\text{X} \) F	ge (In yrs. last birthday) 90 Yrs.	Months Days	Hours Min.	March 25	y, Year)	Cou	thplace (State or Foreign untry) higan
br wor	t a	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		Taren 23	, 1522	1110	10d. Inside City Limits
farylar 8a-f sl	tiffied	ᆢ	Maryland Montgomery	Bethesd						1 ☐ Yes 2 🛣 No
h the N	pe no		10e. Street and Number		10f. Zip Code			_	en of What Co	
ath wit	must	Funeral	9104 Kirkdale Road 11. Marital Status 12. Was Decedent	Ever in U.S. 13 V	Vas Decedent of Hi	314 208			ed Sta	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show	Examiner	þ	1 Never Married 2 Married	? No	f Yes, specify Cuba	n, Mexican, Puerto	o Rican, etc.)		Black, White	
15-0 72 hou "natu	edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa		king	16b. Kind	d of Business/	Industry
212 within giene. er thar	the M		Elementary/Secondary (0-12) College (1-4 or 4	D+)	ONOT use retired) emaker			Own	Home	
land be filed to lental Hyg	event,	To Be	17. Father's Name (First, Middle, Last)	· ·		18. Mother's Nar				
Maryland should be file and Mental I is marked o	matic		Walter R. Meier 19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Address (Street a		eine Dag			
d 2 sh d 2 sh alth an	er trau	Ì	Edward T. Brennan, Jr. / Se		Corsica I	Orive, Be	ethesda,			
Baltimore, Marylar permit. Page 1 and 2 should be foppartment of Health and Menta Important: If item 27 is marked	ury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	e 20b. Place of Disponsion Cemetery, cremetery, cremetery, cremetery	natory or other plac	e) July ry 201) 31, 12		ation - City or	
Balti permit. Departr Imports	any inju		21. Signature of Funeral Service Licensee	M01305 755	Name and Address bert A. Pum 7 Wisconsi	ss of Facility phrey Fune n Avenue, I	ral Home/ Bethesda,	Bethes Maryla	da-Chey nd 2081	y Chase, Inc. 4-3501
Physic	ian/	5	23a. Part 1. Inter the disease, or complications that cause shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition	ed the death. Do not ente						Approximate Interval Between Onset and Death
Med Exam	iner		resulting in death) Due to (or as	s a consequence of):	D1					12413
uted	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consections off						464
760 cate be executed physician and	he burial-t	ledical E	resulting in death) Last Due to (or as H) Li	s a consequence of):	EKOZ					404
687 ertifica ding pl	93		IF FEMALE: 23c. If yes, outcome	e of pregnancy				T		
th c	ched for us	Physician/IV	in the past 12 months?	2 Fetal death 3 at time of death 5	Ectopic pregnand Other (specify)	Sy .		23	3d. Date of del Month	Day Year
S, P.O. Bc lires that the dea signed by the a			Part II. Other significant conditions contributing to death		ınderlying cause giv	en in Part I.	23e. Did t			the cause of death?
fital Records, sician: The law requires certificate has been sign	age 2 shou	Completed by					24a. Was auto perfo		prior to death?	topsy findings available completion of cause of
al H lan; Th rtificat	ō l		25. Was case referred to medical examiner?		26. Pl	ace of Death (Che		2 - No	1 L Yes	s 2 🗆 No
F Vit Physic this ce	≟ I	욘	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpa	tient 2 ER/Outpatien		4 ☐ Nursing F	lome 5 Resi			cify)
on of V ding Phys th. After this	e funeral	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	jury 28b. Time of ay, Year) injury	work		28d. Describe l	now injury o	occurred	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific	ed in by the	Certificate:	3 Suicide 6 Could not be 28e. Place of In	njury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (City or Tov		Vumber or Rui	ral Route Number,
he Hospit in 24 hour he Funera	pletely fille	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of Check only one) 3 Certifying Nurse Practitioner: To the check only one) 1 Certifying Nurse Practitioner: To the check of t	examination and/or inves	tigation, in my opinio	on, death occurred	at the time, date a	and place, a	and due to the o	cause(s) and manner stated.
To t with	COM		29b. Signature and title of certifier White Z. Fine M.)	29c. License	e number 6611			signed (Month	
)			30. Name and address of person who completed cause of 8120 WOODHINK WE	\$370 4	BETHESO	A,MD	2081	4 D	ELIAF	INE MID
Re	State	e ir	31. Date filed (Month, Day, Year) 22. Regist	rar's Signature	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear FLSIE BARNES 7:59PM JULY 20 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SECOURS HASP. BON BAZTIMORE 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 16, 1955 **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖵 F MD Country) 217-66-5921 57 **Director** Feb. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA or items 23a 1117 N. Mount St. death v 11 Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Yes 2 No If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Barnes other traumatic Elsie Bradley permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 N. Mount. St. Balto, Md. 21217 Robert Boyd (son) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X☐ Burial 2☐ Cremation 3☐ Removal from State any injury or July 31,2012 Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 21. Signature of Funeral Service Licens Calvin B. Scruggs Funeral Home E St. Balto, Md 21213 Preston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final PULMONARY Onset and Death - Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to inniediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Yes the 9 Unknown g Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be d YPERTENIS10N 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has funeral director, page 2 autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မူ 1 Mainpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 1 Natural Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending work Accident Investigation 1 Yes 2 No 24 hours after death Funeral Director; filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted Description in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 Many knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23300 JULY 25

State Registrar

A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. PATES

32. Regiptrar's Signature

SUDKIR

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:18 A M Cadwallader Florence 2012 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7801 Peninsula Expressway 301 Dunda1k Baltimore Apt. If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min **Director** 181-18-8408 1 M 2 XF March 1,1922 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 7801 Peninsula Expressway Apt. 301 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Smith Gertrude Menien other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Mr. Timothy Cadwallader(Son) 4057 Hess Road Stewartstown, PA 17363 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 7/30/2012 Middle River, MD 4 Donation 5 Other (Specify) uneral Service Licensee Gre 21. Signatur Reed Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy the atter in the past 12 months?
1 Yes 2 X No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 🗆 No After this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify, completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred e Hospital or Attending Pt n 24 hours after death. e Funeral Director; After the 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No injury Natural 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

mv

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month June TÖ 20 ľ2 6:55 P M Michael L. Carson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Montgomery Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) UNK. **Funeral** Director 243-78-2683 64 1 🕅 M 2 □ F 1947 July 23, 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director ns 23a or 28a-f s must be notified Montgomery Gaithersburg 1 U Yes 2 No 10f. Zip Code 20877 10e. Street and Numbe 10g. Citizen of What Country? USA Funeral 18032 Cactus Court 12. Was Decedent Ever in U.S. Armed Forces? unk
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ed other than "natural", or iten Black White etc þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ent: If Item 27 is marked other than "natural", or Specify: black Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes Give 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry UNK 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18032 Cactus Ct; Gaithersburg, MD 20877 Bessie Evans - wife other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of tImportent: If ite
eny injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board **Director** 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Auter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or surt follure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) metastatic stomach cancer vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury signed by the attending physician and abe detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No q Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 X No Casey House မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6/11/12 29c. License numbe D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd; Rockville, MD 20855 Bindo Joseph

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23 Day 800AM David L. Coleman 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen_Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Days (Month, Day, Year) Director 104-36-2967 1 X M 2 - F 67 Usual Residence of Deced 1945 20 New York nit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland serment of health and Mental Hygiene. ordarts: If item 27 is marked other than "naturel", or items 23a or 28e-f show ordarts: If item 27 is marked other than "naturel", or items 23a or 28e-f show injury or other traumatic event, the Medical Examiner mast he notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No 0denton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PMB 140 1121 Annapolis Road 21113 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 X Divorced Completed Jofeman, DAVID 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) United States Uniform Division <u>Secret Service</u> Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lawrence C. Coleman Adele M. Heiderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health ar Important: If item 27 is eny Injury or other treu once. Kirsten P. Norsworthy / Daughter 510 Cardinal Vista Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State July 25, 2012 4 Donation 5 Other (Specify) Arundel Crematory Odenton, Maryland 21. Signature of Juneral Service Lice 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shody, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Priysician/ Metastatic Unknown Primari Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immedia cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 112 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL MD 21061 31. Date filed (Menth, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Inpatient
5. Social Security Number 6. Sex Arundel Harwood Anne 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 577-68-3524 1 🔀 M 2 🗆 F 62 June 20,1950 SC Usual Residence of Decedent th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Temple Hills MD PG10e. Street and Number 10g. Citizen of What Country? Funeral 4547 Akron Street 20748 <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic eve ance. James E. Cunningham Julia M. Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4547 Akron Street Carletha Cunningham/wife 20748 Date 20b. Place of Disposition (Name of Baltimore, MD. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 7/28/12 Waldorf. Heritage Mem. Cemetery Signa ure of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause an each line. Approximate Interval Between Immediate Cause (Final Property Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or miury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? É AILURE PATITIC 1- Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. performe Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NPT care 1 Yes 20 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title/b

State

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $J_{\mathbf{u}}^{\mathsf{Month}}$ 22, 2012 Didima E. Castro 11:40 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 579-48-9239 Director 1 DM 2 1 F 104 Jan. 2, 1908 Ecuador r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland | Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 104 Fallsgrove Blvd., #3101 United States of America 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 K Yes 2 No Specify: Ecuadorian Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done (life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 1 and 2 should be filed wit of Health and Mental Hygie item 27 Is marked other other treumatic event, 拉 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Agustin Mendoza Rosa Moreira 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Fallsgrove Blvd. #3101, Rockville, MD 20850 Ana C. Peers / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Importent: If its
any Injury or ot 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State cemetery, crematory or other place) Montgomery Crematorium July 26, 2012 4 ☐ Donation 5 ☐ Øther (Specify) Bethesda, Maryland 21. Signature of Funda Robert Addre Full Parity Funeral Home/Rockville, M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure to Thrive disease or condition Medical resulting in death) Due to (or as a consequence of): [']Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events Examine Due to (or as a consequence of): nding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Debility Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 H Other (Sc 1 ☐ Yes 2 🖺 No Hospice ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 July 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D., 6001 Muncaster Mill Rd., Rockville, Maryland 20855 31. Date filed (Month, Day, Year, 32. Registrar's Sig State 2 6 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:00 pm 2012 John Darwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Manor Care of Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 214-74-8817 58 Director 1 🛛 M 2 □ F March 10,1954 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 an "natural", or items 23a o Medical Examiner must be Completed by Funeral U.S.A. 20882 9421 Warfield Road permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Never Worked Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Verle Marlene Turner Walton Spencer Darwin, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9421 Warfield Road, Gaithersburg, Maryland 20882 Janet Butters - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 07/31/2012 4 Donation 5 Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center Katnina 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physicum disease or condition resulting in death) Sersis 1 Week Medical Due to (or as a consequence of): Examiner 1 Week Pneumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or Injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 X No 3 Probably 4 Unknown Down's Syndrome 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy funeral director, page 2 performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ည 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending Accident Investigation by the 24 hours after deat Funeral Director: 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled Medical 29a. Certifier Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

Raman Tuli.

31. Date filed (Month, Day, Year)

M.D ..

2 6 2012

DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

D19609

10810 Darnestown Road, #202, Gaithersburg, Maryland 20878

July 25, 2012

Dietsch, Christopher Matthew 12-05303

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 23698

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		5. Social Security Numb			7. Age (In yrs.	last hirthday/	If Under 1	Vear I If I	Jnder 24Hrs	8 Date of	Rirth/M	M/DD/YYYY)		•	ate or
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nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after it of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	2	3 Widowed 4		or Dates:		16a. Deceden	Yes 2 X			work done	116h	Specify: b. Kind of Bus	whit		nk
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ļ		30. Name and address of Jack Titus MD.		Chief Medica		,	Baltimore S	Street, B	altimore.	MD 2122	23				
St	ate	31. Date filed (Month, D		122 Bas	strar's Signat	ture									
Regist	rar	J	U["26	ZUIZ Z	ener	A. 1	ake								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		4	For State	tate of Ma	aryland					/lental Hy	gien	e		0000
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DHMH 17 Rev 06-2011

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		I	Usual Residence of Decedent	- W 2 3231	72 Yrs.			9-8-193	59	VA
/land f show	호	1	0a. State 10b. County		10c. City, Town or L	,				10d. Inside City Limits
Mar 28a-	ie	L	DC N/A		Washin					1 🗆 Yes 2 🔼 No
vith the Maryland 23a or 28a-f sho st be notified at	1 <u>e</u>	[0e. Street and Number	1 11/		10f. Zip Coo	0001	100	g. Citizen of What C	Country?
036 s after death with ral", or items 23 Examiner must	Funeral Director	1	1. Marital Status	12. Was Decedent Ev	ver in U.S. 13			Specify Yes or No-	14. Race - Am	perican Indian
6 er de or ite			1 Never Married 2 Married	Armed Forces? 1 Yes 2 X	No		of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	Black, Wh	ite, etc.
5-003 2 hours aft "natural",	led I		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀	No Specify:		Specify:	slack
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. J other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Completed by		15. Decedent's E (Specify only highest gr		(Give	edent's Usual Oc e kind of work do	ne during most of wo	orking 16	b. Kind of Busines	s/Industry
thin 7 sine.	100		Elementary/Secondary (0-12)	Callege (1-4 or 5-	-) life.	DO NOT use reti	e Dina	1	Lilla L	Litel
d 2 led will Hygiv other ent, t	Be (7. Father's Name (First, Middle, Last)	Tyrs.		1130 14		ame (First, Middle, Mai	den Sumame)	1019
lan be fillental reked tic ev	욘	1	James E. Woo	ds			Vini	a P. F	errell	
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth traumatic event		1	9a. Informant's Name/Relationship (1		19b. Mai	ling Address (Str		ural Route Number, Ci	ty or Town, State, 2	Zip Code)
, M nd 2 s ealth m 27		Ĺ		on-Niece	500	9 60	vane f	tve. Ba	Himore, 1	1021212
Baltimore, Maryland 21215-00 permit. Page 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical		2	0a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other	f place)		c. Location - City	
timo t. Page tment c tant: If		L	4 Donation 5 Other (Speci	fy)	11 11 / " "	rmel	7/3	12012 6	Baltimore	MD
Ball permit Depar Impor any in	ouce.	2	1. Signature of Funeral Service Licen	500 H (1)		22. Name and Ad	1 1	March - E	ast	
		+	23a. Part 1. Enter the disease, or com	plications that caused			North Av		ore, MD	2(202 Approximate
Photostate			shock, or heart failure. List only o	ne cause on each line.			aying, odon ad daraid	N		Interval Between Onset and Death
Phyticia Medic		11.4	disease or condition resulting in death)	d.	consequence of):	cad Injury		1		
Examin	•	ı						A THE		
	ine.	L	Sequentially list conditions, if any, leading to immediate bases. Enter Underlying	Due to (or as a	consequence of):	1	7.7	ICH EXAMPLE		
executec an and rial-trans	Examiner		Cause (Disease or injury that initiated events	C. Due to for on a		(_y .[THE REPORTED BY ME			
requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	<u>8</u>	1	resulting in death) Last	Due to (or as a	consequence of):	CERTIFIC	NALIDA MASSONED BI MET			
760 cate b	edic			d						<u> </u>
Box 68760 death certificate be attending physical for use as the k	Ž	IF.	FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of c	lelivery
SOX eath c atter	icial		in the past 12 months?	4 Pregnant at	Petal death 3 time of death 5	☐ Ectopic pregr ☐ Other (specif)			Month	Day Year
D. E the d the by the tacher	hys		9 🗌 Unknown	9 Unknown						
P.O. s that the gned by t	Completed by Physician/Medic	· F	art II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying caus	e given in Part I.	23e. Did tobac		to the cause of death?
'ds,	ted	J-						1 🗆 Yes	2 No 3 □	Probably 4 Unknown
COI law re nas be e 2 sh	롈	.						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Re: The cate I	ပို	L						performe 1 Yes 2	d? death?	es 2 No
ital sician certifi	Be	2	 Was case referred to medical examiner? 1 ✓ Yes 2 No 	Hospital:			6. Place of Death (Ch. Other:			
Division of Vital Records, rate of attending Physician: The law requires s after death. In Director After this certificate has been signed in by the funeral director, page 2 should be	2	2	7. Manner of Death	28a. Date of injury	nt 2 ER/Outpati / 28b. Time	ent 3 L DOA	4 ☐ Nursing	Home 5 Residence 28d. Describe how		ecify)
on C ading ath. : Afte	cate	ı	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day,	Year) injury 2012 9:11	_ \	work?	Subjec		1
ision Attendii er death. ector: A	Certificate:	1	3 Suicide 6 Could not be 4 Homicide determined	10	y - At home, farm, s		ice	28f. Location (Stree	et and Number or F	Rural Route Number,
Div Ital or Its aft al Dir				HOSP	1+ cu 1				leans 5	
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	2	(Check 2 Medical Exam		amination and/or inve	estigation, in my o	pinion, death occurred	d at the time, date and p	place, and due to the	e cause(s) and manner stated.
the lithin 2 the lim 2 the lim 2	Me			se Practitioner: To the		e, death occurred		place, and due to the c		as stated.
P ≥ P ⊗			ob. Signature and title of certifier	< Mi	>			290	. Date signed (MOI	77 2/1
		2	0. Name and address of person who				5-000	<u> </u>	une 1	
31		1	Wan - 7sh chang				et Bal	timore	md	21287
5	tate	3	1. Date filed (Month, Day, Year)		's Agnature					
Regi	trar		IIII 2 6 2012 /2	Level W. J.	CO CANON					

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State of Maryland / Department of Health and Mental Hygiene

2012 23701

Roberta Laveri		1- For State Registrar Certi	ificate of E			eg. No.	
hysician/ Medi Exam		Decedent's Name (First, Middla,Last)			2. Date of Dea Month July 19, 2	Dav Year	3. Time of Death
		4a. Facility Name (if not institution, give street and number)		City, Town, or Location		4c. County of Dea	
Funeral		751 West Saratoga Street #308 5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year If Und	er 24Hrs. 8. Date of Bi	N/A	irthplace (State or Foreign
Director		220-38-7161 1 _{□M} 2 ∑ F	70 Yrs.	Months Days Hours	Min		MD
śwe		Usual Residence of Decedent 10a. State 10b. County 10c, City, T	own or Location				10d. Inside City Limits
Maryland 28a-f show any datome	ō		timore				1 Yes 2 No
ith the Mary 23a or 28a notified at	Director	10e. Street and Number 751 W. Saratoga St. #308	1	10f. Zip Code 21201	1	0g. Citizen of What Cot USA	intry?
after death w 11", or items	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced Yes Care Yes	If Yes	Decedent of Hispanic Original Specify Cuban, Mexican es 2 X No specify:	n, Puerto Rican, etc.)	14. Race - Ame White, etc. Blac Specify:	rican Indian, Black,
5-0036 led within 72 hours : Hygiene, other than "nature	mpleted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most	Usual Occupation (Give k t of working life. DO NOT g Assistal	use retired)	16b. Kind of Business John Ho	
Baltimore, MD 21215-0036 Opent. Pages 1 and 2 should be filed within 7 Opentment of St land 2 should be filed within 7 them 27 is marked other than hijury or other traumatic event, the Melles injury or other traumatic event, the Melles injury or other traumatic event, the Melles in	Ве Соп	17 Father's Name (First, Middle, Last) William Thrower		18.Mother	's Name (First, Middle, M	faiden Surname)	<u> </u>
212 hould b nd Meni is mari	To E	19a. Informant's Name/Ralationship (Type, Print.)	19b. Mailing A	ddress (Street and Nur	mber or Rural Route Nun	nber, City or Town, State	
ore, MD 21219 ss I and 2 should be fill of Health and Mental I If tem 27 is marked her traumatic event, I		Janean Davis-Daughter 20a, Method of Disposition 120b. Pla		 Saratoga n (Name of cemetery, 	a St. Bal	timore, M. 20c. Location - City of	ID 21201
Baltimore, cernit Pages 1 ar Department of Hea Important: If the		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify	amatory or other	orial Pk.		 Randall	stown, MD
Baltimo pernit. Page Department Important: injury or od		21. Signature of Funeral Service Licensee		ne and Address of Facility 1 E. North			MD 21202
Physician /Medical		Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. Immediate Cause (Final disease Wypertensive Atheroscle			rdiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	ouc Gardiov	asculai Disease			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Checogo or their united initiated					
ecuted and transit		(Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of).					
cian cian	/Medical	UNPENDED AMENDED					
Box 68760 e death certificate b the attending physical ed for use as the bu	ian	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown 23c. If yes, outcome of pregnant in the pregnant at time of death 23c. If yes, outcome of pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal	death 3 Ectopio	c pregnancy	23d. Date of deliver Month	y Day Year
O. B at the da if by the	Physic	Part II. Other significant conditions contributing to death but not result	Iting in the under	rlying cause given in Part	1. 23e. Did to	phacco use contribute to	the cause of death?
S, P.O. urres that the n signed by Id be detach	eted by	Cancer			1 Ye:	2 No 3 Pro	obably 4 X Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attaching Physician: The law requires that the death certif within 24 hours after death. To the Runeral Director: After this certificate has been signed by the attending completely filled in by the fameral director, page 2 should be detached for use as	Complet				24a. Was autor perfo 1 X Yes	osy prior to crited? death?	utopsy findings available completion of cause of
ital iclan: s certifi rector,	å	25. Was case referred to medical examiner?	D/O to divide	26.Place of Death			
of V ig Phys ifter thi	2	27. Manner of Death 28a. Date of Injury 2	R/Outpatient 3 8b, Time of Injur			Residence 6 X Other	Scene
Sion Attendir death ector: A	cation	2 Accident S Pending Investigation		1 Yes 2	<u>'</u>		
Divi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom (Specify)	e, farm, street, f	actory, office building, et	c. 28f Location (S or Town, S	Street and Number or Ru State)	ural Route Number, City
o the Ho ithin 24 h o the Fw ompletely	Medical	29a Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/a					
PERO	Me	29b Signature and title of certifier		29c. License number	-		
	}	30. Name and address of person who completed cause of death (Item 23)	a)	O.C.M.E.		July 20, 2012	
41		Laron Locke MD. Assistant Medical Examiner 9	•	nore Street, Baltimo	ore, MD 21223		
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	and a				

ORIGINAL

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Laron Locke MD.

32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iarion Eldridge		State of Maryland / Department of Health 1-For State Certificate of Death		ene Reg.	201	2 2370
Physici				ate of Death	ay Year	3. Time of Death
ledical Exam	iner	Marion Eldridge	Jul	ly 17, 201	2	2213 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, To 5506 The Alameda Baltim	own, or Location of Death ore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	r 1 Year If Under 24Hrs. 8. D	Date of Birth (MM/DD/YYYY) 9. Birt	
Director		219-32-8813 1 M 2 X F 76 Yrs. Months	Days Hours Min. Ma	arch 3	0, 1936 Foreig	n untryMaryland
ě.		Usual Residence of Decedent				40d Incide City Limite
OW any		10a. State 10b. County 10c. City, Town or Location Baltimore				10d Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	ctor	10e. Street and Number 10f. Zip (Code	10a.	Citizen of What Cour	
the Ma sa or 28	Director	5506 The Alameda 21	.239		USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner, must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent In U.S. 14. Marital Status 15. Married Armed Forces? 17. Never Married 2 Married Armed Forces? 18. Was Decedent Ever in U.S. 19. Married If Yes, specify	t of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rican		14. Race - Americ White, etc.	can Indian, Black,
her de		1 3 1 Midoward 1 1 Divorced III Yes Give Year 1 1 Voc 2tt	No specify:		Specify: R1	ack
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be C		Luella Jor		adir damame,	
21, ould b d Men s mar	To E		(Street and Number or Rural F		er, City or Town, State,	Zip Code) unk
MD 2d 2 sho ath and m 27 is	i	JoAnn Russ - daughter 20a. Method of Disposition 20b. Place of Disposition (Name	The state of the s		20c. Location - City or	7 0.7.
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)	e of cemetery, Date		oc. Location - City or	rown, state
fir Pag rtment rtant:		4 X Donation 5 Other Specify:	uddrags of Eacility Classes	<u> </u>	. D. 1	
Bal perm Depa Impo injur		I A THE THE D. MICHIGAN DELECTION	^{address of Facility} State • Baltimore St		-	21201
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical Examiner	ì	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease con	mplicated by Hypertheri	mia		Death
		or condition resulting in death) Due to (or as a consequence of):				
	Jer	Sequentially list conditions, if any, leading to immediate ————————————————————————————————————				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
cuted nd ransit						
60, tte be executed hysician and e burial - transit	ledical	UNPENDED AMENDED				
Box 68760, death certificate be the attending physic ed for use as the bur			3 Ectopic pregnancy		23d. Date of delivery Month D	ay Year
30x 6876 death certificate e attending phy for use as the l	iciai	past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specif			World D	ay rear
Bo he dear the at hed for	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown		20 - D' 14-1	-4-9-4-4-4-4	(1-10
ires that the signed by	by				cco use contribute to t 2 No 3 ✓ Prob	
ds, equire een sig ould be	ompleted			24a. Was an		topsy findings available
cor e law r e has b e 2 sh	de		 .	autopsy performe	ed? death?	ompletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s	ပ	0.00	5.Place of Death (Check only or		No 1 ✓ Ye	s 2 No
of Vital Records, g Physician: The law requir. ther this certificate has been si neral director, page 2 should b	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	Other -		sidence 6 🗸 Other	Scene
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SiOn Attend death. ctor:	atic	1 Natural 5 Pending FOUND: 2 ✓ Accident Investigation FOUND: 2040 hrs	1 Yes 2 No			
Division pital or Attendia ours after death. ceral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse		ocation (Street or Town, State The Alame	eet and Number or Rur e) eda, Baltimore, MD	ral Route Number, City
			ime, date and place, and due to	o the cause(s	s) and manner as state	
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.				
	Σ		C.C.M.E.		9d. Date signed (Mon	ith. Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)			July 18, 2012	
			timore Street, Baltimore	e, MD 212	23	
	tate	0 0 00				
Regis DHMH 17 Rev 1/2		Charles B. Carles				
DIMMIT IT REV 1/2	.501	ORIGINAL		20115	0	ChaE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2:24 AM Marie beorgia 2012 Medical 4a. Facility Name (if not institution, give street and number)
PICASANT VIEW NUMBER HOME
4.00 DIA NATIONAL PINE
5. Social Security Number
6. Sex 7. Age (in yr 4b. City, Town, or Location of Death 4c. County of Death Examiner Moun Carrol 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/05/1938 If Under 1 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗆 F Months Days Hours Min. Country) 73 Director 212-40-8159 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Md. Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4101 Old National Pike 21771 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc Š 1 ★ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Office/Homes Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Monroe Edwards Lilah Gilley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12511 Brandenburg Hollow Rd. Myersville, Md 21773 Loretta Dinges (Niece) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State All County Cremation 07/26/2012 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europa Service Licer 22. Name and Address of Facility Haight Funeral Home & Chapel 11/1 P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of : ARTERY DISEASE disease or condition Medical resulting in death) Examiner Hy PERTENSION Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 ☐ Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ALZHRIMER'S DEMENTIA Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed PARKINSON'S DISEASE 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) | [2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) well B D.30469 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt)

N 13-VELLANKI, 8850, COLUMBIA 100 PARKWAY, # 308, COLUMBIA;

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 6 2012

32. Registrar's Signature

			Please	Type or Print and item 17 State of Mar	in Black	Indelible In 1929 7–26 Partment of I	k. Ensure A -12 vt Health and	All Copie Mental Hv	s Are Le	gible.	
		•	For State Registrar			ertificate of			Reg. No. 2	012	23708
	Physicia	n/	Decedent's Name (First, Middle, Las	Nova	Lee	Eva	hc	2. Date of De Month	Day	Year	3. Time of Death O//45 M
* 4	Medic Examin		4a. Facility Name (if not institution, give	1 10,00	222		or Location of Death			2012 nty of Death	01,93
			Gilchrist 1-	tospice		1 1	If Under 24 Hrs.	Topi (a)	Ba		
	Funeral Director		5. Social Security Number 6. Sec. 2/7- //o-8728 1	ox / 7. Age (li □M2 12 17 F	n yrs. last birthday	Months Days	Hours Min.	(Month, Da	y, Year)	9. Birthp Coun	11.
	Mor #	_	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or I	ocation		8-5	-1922		(Od. Inside City Limits
	filed within 72 hours after death with the Maryland that Hygiene. Atal Hygiene. Attent then "natural", or items 23e or 28e-f ahow event, the Medical Examiner must be notified at	Director	MD	NA	Baltin						1 Yes 2 □ No
	h the h	al Di	10e. Street and Number		9-17/11	10f. Zip Code			10g. Citizen o	f What Cour	itry?
	ath wit	Funeral	814 Carter Au 11. Marital Status	12. Was Decedent Eve	rin IIS 13	. Was Decedent of I	1218	necify Ves or No-	<i>L</i>	LJA	an Indian
9	or ite	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		ace - Americ lack, White, o	etc.
21215-0036	ours af ntural" at Exe	eted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	110.5	1 ☐ Yes 2 🗖 No			Speci		lach
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ary	2 should by the and Mer 17 is market traumetic		19a. Informant's Name/Relationship (7)	pe, Print) Dang	(.L. 19b. Ma	iling Address (Street	and Number or Ru			, State, Zip (Code) 19605
	= 54		Corraine Pe	a cock being	17	41 600	wel Hi	ill Drw		King	-
Baltimore,	. 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, cr	position (Name of ematory or other pla	1 2	Date	20c. Locatio	n - City or To	wn, State
i	permit. Pege 'Depertment or Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Liçens	<u> </u>	Thait	CLM eq 22. Name and Addre		3-2012	Dal	70, M	<u>/)</u>
Ba	Dep du any		> Smurt	TNO		1101 E	North	Svenu	e Ba	1 to M	0 21202
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	plications that caused the cause on each line.	e death. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	13	Approximate Interval Between
P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Aspt	ration	PNEU	novia			_	Onset and Death
	Examiner			1	ncentre on:	1					Urans
	p #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):						
	executed en end rial-trens	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):						
		lcal		d			***				
Box 68760	Ine law requires that the death certificate be rate been signed by the ettending physici page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE:	00 - 16							
×o	ettence ettenc	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 Live Birth 2 L 4 Pregnant at tir	Fetal death 3	Cother (specify)	су			Date of delive Month	ery Day Year
	t the de by the stached	Phys	9 🗌 Unknown	9 🗌 Unknown							
s, P.O.	es tha signed	þ	Part II. Other significant conditions of Part Wolvair 657	-	-			23e. Did t	١.		ne cause of death?
ord	requi	Completed	Cendula		1.000		o lat	24a. Was		o. Were autor	psy findings available
Sec.	fhe lav ate hes page 2)omo	wyc					auto perfe		prior to condeath?	mpletion of cause of
ta .	cien: ertifica ector, I	Be	25. Was case referred to medical examiner?	Hospital:			lace of Death (Che		2,001	100	
) 	Attending Physicien: ar death. ector: After this certific by the funeral director.	일	1/2 Yes 2 ☐ No 27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpat	ient 3 🗆 DOA		lome 5 Resident			Hospia
0	anding sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation		(ear) injury	wor					
		Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined	28e. Place of Injury building, etc. (5		street, factory, office		28f. Location (S City or Tox		ber or Rural	Route Number,
Ω	Hospital or 24 hours afte Funeral Dir stely filled in	Medical	29a. Certifier Certifying Phys	sician: To the best of my	/ knowledge, deat	n occurred at the tim	e, date and place,	and due to the c	ause(s) and ma	nner as state	ed.
;	the Ho hin 24 the Fu aplete	Med	only one) 3 L Certifying Nurs	ner: On the basis of exam se Practitioner: To the be	nination and/or invest of my knowledge	estigation, in my opin ge, death occurred at	ion, death occurred the time, date and p	at the time, date a place, and due to	and place, and o the cause(s) and	lue to the cau I manner as s	use(s) and manner stated. stated.
	6 ≱ 6 §		29b. Signature and title of certifier	440		29c. Licens	se number 5830:	3	29d. Date sign	ied (Month, L	Day, Year)
	0 1		30. Name and address of person who o			, Print)) 5830 Charle		-01-7		
	91		AMRON' Z C	1 1		01 10	Charle	ST	Tousa	V My	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 14ay 20ไว้ 7:01 Vivienne Bernadette Foehser Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 36651 Knotts Lane Mechanicsville St. Marys Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 214-78-3218 1 □ M 2 🔀 F 90 Director Yrs Usual Residence of Decedent 1921 21, Maryland ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Pasadena 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 90 Pine Rd. 21122 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? 0 þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be filed and Mental H John Matthew Vrsalovich Lucy Martha Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36880 Dog Park Lane; Mechanicsville, MD 20659 Lucy Howlin - niece If item 27 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Funeral Servi 21. Signat 22. Name and Address of Facility State Anatomy Board Mrector Rona 1d Wade, 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical Box 68760 as the nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ for in the past 12 months?

1 Yes 2 Ato Pregnant at time of death Month Day Year ☐ Yes ∠ . ☐ Unknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? Yes 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 Ko ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 7. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at 28d. Describe how injury occurred 1.XNatural 5 Pending n 24 hours after death. e Funeral Director: After the further of the further t 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Pecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely f 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

Three Not

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

28/03

aren L Baum MD

JUL

31. Date filed (Month, Day, Year)

D62042

Site 101 Mechanicsville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar				d Mental Hy	giene	2 22700
			Registrar		Cer	tificate of D	Death		Reg. No. 4UI	2 23708
т	Physicia	ın/	Decedent's Name (First, Middle, Last)	-				Date of Dea Month	ath Day Yea	3. Time of Death
	Medic		Malcolm Vernon Ful 4a. Facility Name (if not institution, give stree			4b. City, Town, or	Longtion of Do	July	19, 201	= 121.00
1	Examin	er	Patuxent River Heal	•	Ctr	Laurel	Location of De	aatri	4c. County of De	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 H		h 9. E	Birthplace (State or Foreign
	Director			12□F 8	0 Yrs.	Months Days	Hours M	fin. (Month, Day Aug. 6, 1		Country)
	nd now	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	10c Gi	ty, Town or Loc	ration		1149.072		10d. Inside City Limits
	arylar a-f sl	To Be Completed by Funeral Director	MD Prings Coo							1 ∰Yes 2 □ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. And any injury or other traumatic event, the Medical Examiner must be notified at once.		MD Prince Geo 10e. Street and Number	rge La	urel	10f. Zip Code			10g. Citizen of What	
			7609 Kilbarron Dr.			20707			USA	,
				Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin?	(Specify Yes or No-		nerican Indian,
36			1 L Never Married 2 Married	1 X Yes 2 No If Yes, Give		☐ Yes 2 🔀 No		erto filoari, etc.)	Black, Wh	_{lite, etc.} cican-Americar
8				Year or Dates.		ent's Usual Occupa				
75	an "n Medin		(Specify only highest grade of	ompleted)	(Give k	rind of work done d NOT use retired)		working	16b. Kind of Busines	s/Industry
212	within giene. er tha , the [Elementary/Secondary (0-12)	College (1-4 or 5+)	Drywa	ll Finis	her		Construct	ion
nd	filed tal Hy d oth event		17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surname)	
yla	2 should be th and Ment 27 is marke traumatic		Theodore Fullum				Loric	ce Fullum		
Mai			19a. Informant's Name/Relationship (Type, F Ethel M. Fullum/ Wi					Rural Route Number Laurel, N	r, City or Town, State, I	Zip Code)
re,	f Heal		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	T		20c. Location - City	or Town, State
Baltimore, Maryland 21215-0036	Page 1 nent of nnt: If i		1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)			Mem. Par	e) Ju k 2	11y ^{Date} 26, 2012	Clarksvill	
3alt	permit. Departr Import, any inju		21. Signature of Funeral Service Licensee		22.	Name and Addres	s of Facility	onaldson	Funeral Ho	ome, P.A.
_	= a o	- 5	J. Kein Skilas	M0105				Laurel,		
	mulician/ Medical		23a. Fart 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final	use on each line.					est,	Approximate Interval Between Onset and Death
A CONTRACTOR			disease or condition resulting in death)	2 HEIMER DEMENTIA					Onset and Death	
TO A S	Examiner			Due to (or as a consequ	uence on.					
1		dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	quence of):						
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h			resulting in death) Last							
209	cate I	ledio	d							
1687	eath certifica attending p	by Physicia	IF FEMALE: 23b. Was decedent pregnant 23c.	ancy al death 3 Ectopic pregnancy death 5 Other (specify)				23d. Date of c	lelivery	
Вох	death he atte ed for		1 Yes 2 No					Month	Day Year	
i, P.O. E	been signed by the should be detached		9 🗆 OHKHOWH	g Unknown	udian in the co	alad in a second of	en la Dest I			
			Part II. Other significant confidens contrib	in son	DISEC		en in Part I.		res 2 No 3 No	to the cause of death? Probably 41 Unknown
Records,		Completed	,	•						autopsy findings available
မင္ပ	ine law ate has page 2 :	dmc						24a. Was a autop		completion of cause of
<u>~</u>	ificate or, pa		25. Was case referred to medical			26 Pla	ce of Death C	1 Yes	2 No. 1 Y	es 2 PNo
Z Z	ysician: is certific director,		examiner? 1 Yes 2 No	ital: 1 Inpatient 2	ER/Outpatien	Othe	r . /		lence 6 Other (Spe	acitul
to t	or Attending For ther death. irector: After the in by the funera			28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at		ow injury occurred	sury
on		Certificate:	1		,,		Yes 2 ☐ No			
Division of Vital		Cert	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	spiral or lours afte neral Dir filled in		29a. Certifier 1 Certifying Physician	: To the best of my know	ledge death o	courred at the time	date and plac	e and due to the ca	use(s) and manner as	etated
1	within 24 hours at To the Funeral D completely filled i	Medical	(Check 2 Medical Examiner: 0 only one) 3 Certifying Nurse Pra	On the basis of examination	n and/or investi	gation, in my opinior	1, death occurre	ed at the time, date ar	nd place, and due to the	cause(s) and manner stated.
			29b. Signature and title of certifier	A 0	\wedge	29c, License	number		29d. Date signed (Mar.	th, Day, Year)
			MV	<u> </u>	<u> </u>	کلا ا	1515		7	20112
	Dx,	30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) MITUL DAVE OUS CHEVROLET DR EULOTICITY MD 24047 31. Date filed (Month, Day, Year) JUL 2 6 2012 2. Registrar's Signature JUL 2 6 2012							10 21042	
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ure face	Les .				
			NO.	1	* /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month July Norman Neal German 13 9:54 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 505 Congress Avenue #203 Harford Havre de Grace Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours 219-22-7756 84 1 X M 2 □ F **Director** Usual Residence of Deced Jan 27, 1928 Maryland or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be r Funeral 21078 USA 505 Congress Ave; Apt 203 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? 1 Nes 2 No 1944-Black, White, etc. 0 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced 1945 Specify: white Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) custodial janitor 12 should be filed with lith and Mental Hygier 27 is marked other t r traumatic event, the unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alice Haim Neal German 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12111 Park Heights Ave; Owings Mills, MD 21117 . Page 1 and 2 sh ment of Health a tant: If item 27 is Donald Edward German - brother Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Sign Ronald S. W Director 655 W. Baltimore St; Baltimore, MD 21201 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians 1 - 1 Atheroscleratic cardiovascular disease disease or condition resulting in death) in medicity Medical Examiner Sequentially list conditions, Examine Disk to (or as a nonsequence of, cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform a abetes mellitus After this certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type,

Registrar
DHMH 17 Rev 06-2011

State

Date filed (Month, Day, Year)

i0

Baltimore, MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claire L. Graham July 24 2012 3:35 Дм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 220-48-9338 Director 1 □ M 2 🏹 F 63 Yrs. Feb. 16,1949 Maryland itam 27 is marked other than "natural", or itams 23a or 28a-f abov other traumatic event, the Madical Examinar must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director N/A Maryland Baltimore City 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 4811 Lindsay Road, Apt. 10 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify. If Yes, Give White Specify: 3 Divorced 4 Divorced Completed ear or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hyglene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Agora Publishing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dapartment of Health and Menta Important if Itam 27 is marked any Injury or other traumaticance. မှ Arthur Burns Graham Amanda Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Hilton Avenue, Catonsville, Maryland 21228 Lynda Bell / Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Mem 1 Park Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/26/2012 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility MacNabb Funeral Home, P.A. Taylor 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Lisease or injury ata has baen signad by the attending physician and page 2 should ba detached for usa as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 📉o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) HOSPICE 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending To the Hospital or Attandin within 24 hours after death.

To the Funeral Director: Aft completely filied in by the fu work?
1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, **CRNP** TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 2 6 2012

DHMH 17 Rev 06-2011

Registrar

2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

17,18 per fh g929 7-31-12 vt

State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 201 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $20\overset{\text{Year}}{12}$ Barbara Ann Houck July 2:00PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1152 Chrome Hill Road Harford Jarrettsville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours Min. Oct 4. 1937 232-60-0195 74 West Virginia **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10d. Inside City Limits Director Harford Jarrettsville 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1152 Chrome Hill Road 21084 **USA** and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Insurance Industry of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clatterbuck Parren H. Clasterbuck Ella Peter - Teter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Robin E. Coy, Daughter
20a. Method of Disposition 1152 Chrome Hill Road Jarrettsville, MD 21084 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 a ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 Donation 5 Other (Specify) 107/26/12 Baltimore, Maryland Signature of Funeral Service Licensey Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Annroximate Interval Between
Onset and Death Immediate Cause (Final Physician/ CIRRHOSIS > Years disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-trans Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician is be detached for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director: After this certificate has been sign cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0070043 JULY 26, 2012 manso 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street Suite 4105 Baltimore, Maryland 21204 Robin Manson 31. Date filed (Month, Day, Year)

JUL 2 6 2012 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25, PER ME G929 7/24/12 TRT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05/23a/201v2ar 3. Time of Death Physician/ Jose Angel Hernandez 6:10 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 613-56-2544 50 Director 1 **⊠**M 2 □ F 1/14/1962 El Salvador Usual Residence of Decedent show death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 ☐ Yes 2 No Silver Spring MD Montgomery ō 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n Funeral 12819 Crisfield Road 20906 Salvador 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten I Examiner n 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 XYes 2 ☐ No Specify: Salvadoran Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 I of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Landscaper Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eduardo Bonilla Maria Luisa Hernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 Cindy Hernandez-daughter 2358 Glenmont Cir. #208 Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 6/2/12 Silver Spring, MD Gate of Heaven 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22 Name and Address of Facility Wanda Macon cc0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physicson/ Brain Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Intracranial Hemorrhage Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). CERTIFICATION APPROVED BY MEDICAL EXAMINER that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as. IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Dav Pregnant at time of death the be detached 1 ☐ Yes 2 ☐ Unknown Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy perform Yes 2 XNo 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Marse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month. Dav. Year) D68150 05/24/2012 person who completed cause of death (Item 23a) (Type, Print) and address Nejib Siraj 1500 Forest Glen Road Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner Decou Imock If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)unk e (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours April 8. Year) 944 Yrs 218-62-2148 68 Director Usual Residence of Decedent 28a-f shov 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at the Maryland Director 1X Yes 2 No Baltimore MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 23a Funeral 21223 with 429 S. Pulaski St. or items filed within 72 hours after death at Hygiene. unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? unk 11. Marital Status 14. Race - American Indian, Black, White, etc. white þ 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other transment Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 W. Baltimore St; Baltimore, MD 21223 19a. Informant's Name/Relationship (Type, Print) Bon Secours Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 🛛 Other (Specify) in state 21. Single of Funeral Service Licentage, Director 22. Name and Address of Facility State Anatomy Board W. Baltimore St; Baltimore, MD 21201 655 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events as a confequence of): Examir burial-transi Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No should be detached for 5 Other (specify) Month Year Day Pregnant at time of death the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has page 2 certificate 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certific director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: ၉ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending injury Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one) 29b. Signature and title of certifie 29c. License numbe 29d, Date signed (Month, Day, Year,

State Registrar 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

6 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend #12 per DVR G930 8/9/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AM 045 LEROY 1 HIGOS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SILUER MONTGOMER 2085 HOSPITA ING HOL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 D F 19-42-2677 Director 3,16,1942 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland at Director notified 1 Ves 2 No MONTGOMER NER SPRIN 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ō must be Funeral 23a **IISA** PISCAH 090 MOUNT 12. Was Decedent Ever in U.S. unk permit. Page 1 and 2 should be fled within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: 3 ₩Widowed 4 ☐ Divorced NHI C. E. Completed Year or Dates 16a. Decedent's Usual Occupation unk (Give kind of work done during most of life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVER 27 SPRING, MD, 20910 MZ HOLY CROSS HOSPITAI FOREST GI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 22. Name and Address of Facility State Anatomy Foard Sign for Euneral Services icenses, Warte, Virector 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be $\#/\mathcal{Z}$ Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the and be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PAROX BRILLATION 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has autopsy performed death? 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \sum Yes 2 \sum No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 24 hours after death. Funeral Director: A Investigation 2 Accident
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier AND) 686 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN RN S.S. MD. MARRSHWARY WD L 2 6 2012 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irene Hollar Month 7:08ам Medical July 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson cial Security Number 8. Date of **29**(Month, Day
June 19 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign Year) 930 218-28-4029 Country) Director 1 □ M 2 ☐¥ 82 MD Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. I them 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Rosedale 1 Yes 2 200 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 1402 Mt. Airey Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blanche Sheffield Edward Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1402 Mt. Airey Road Baltimore MD 21237 Joseph Hollar Jr. /husbahd Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Depertment of Important: If it eny injury or o 1 🖾 Burial 🛪 🗆 Cremation 3 🗆 Removal from State Oak Lawn Cemetery 7/28/12 Baltimore MD 4 ☐ Denation 5 ☐ Other (Specify) 21. Sig ture f uneral Se 22. Name and Address of Facility vice kicens 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death))AU Medical Due to (or as a consequence of): Examiner infection and closhzioium officile tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury day Examine Colifu been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 18 months?

1 Yes 2 No Month Day 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autonsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA MOSPIC 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (M)6701 NI TONSON 31. Date filed (Month, Day, Year) 82. Registrar's Signature Registrar

			Please AMEND #26, PER M	Type or Print in	Black in	delible In	k. Ensure A	All Copie	s Are	Legible.	
		-	Please Type or Print in Black Indelible Ink. Ensure All Copies A AMEND #26, PER MD G929 7/26/12 TRT For State State State Registrar Certificate of Death Reg.					Reg. No.	201	2 23716	
	Physicia	n/	1. Decedent's Name (First, Middle, La.	' / 0	/ 0			eath Day	Year	3. Time of Death	
	Medic	al	4a. Facility Name (if not institution, give	nomas H	art, J	Ab Ciby Town o	r Location of Death	-Zoly	10	2012 County of Deat	7:54 AM
	Examin	er	^	L of Bultimore		Bolling		•	40.	County of Deat	n
	Funeral Director		5. Social Security Number 3. Social Security Number 3. Age (In yrs. last birthday) 4. Age (In yrs. last birthday) 5. Social Security Number 4. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 7-18-1936 9. Birthplace (State or Foreign Country) Towns North Country)								
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Bath and Mental Hygiene. To sharked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits D_{α}/F_{α} 10d. Inside City Limits 1 D_{α}/F_{α} 10d. Inside City Limits 10d. Inside City Lim								
	the Ma or 284	Funeral Director	10e. Street and Number		MIHIN	10f. Zip Code			10g. Citi	zen of What Co	
HART	h with ns 23a nust b	nera	2319 Poplar	Grove			21216			USE	7
	or deat		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	lf '	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		 Race - Ame Black, White 	
S. CERLTON	ural", ural"	ted b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:			Specify: B	lack
18.87 TU.R.	72 hou 72 hou n "nata fedica	To Be Completed by	15. Decedent's E (Specify only highest gr	rade completed)	(Give ki	ent's Usual Occup nd of work done NOT use retired	during most of work	king	16b. Kii	nd of Business/	Industry
	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	Sec	vrity	Office	er	50	cial	Security
A A5:	be filed ental Hy ked oth ic event		17. Father's Name (First, Middle, Last)								
Known A	ould be ould be nd Menta marked imatic e		19a. Informant's Name/Relationship	Type, Print) . 501	19b Mailing	Address (Street	and Number or Rur	al Route Numb	er. City or	Town, State, Zin	Code)
	and 2 sh Health ar Health ar em 27 Is		Carlton Thoma	I	6000	Lycei	,	e Mar			20112
PRITEUNT	n 0 = -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispos cometery, cremi	ition (Name of atory or other pla	ce)	Date	20c. Lo	cation - City or	Town, State
PATE	permit. Page permit. Page lepartment o lmportant: If any injury or once.		4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee / 22. Name and Address of Facility License C. Specific Funeral Services								
Ó	permit. Departrimporta		Vaucher C. Prune 8728 Liberty At Randa 1/5town MO 21/33								
		Examiner	23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard ailure. List only one cause on each line. Approximate Interval Between								
1	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death More than 2 hors								
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5	at d		Sequentially list conditions, b. Dianto (ur as a consequence of): cause. Enter Underlying							- 5	> 12
	executed an and rial-transi		Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							> 10 years	
ç	e be e ysiciar ne buri	lical	d								
070	ortificat ling ph	/Mec	IF FEMALE:	23c. If yes, outcome of pre	gnanov						
	requires that the death certificate be executed requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transitions.	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year	
6	t the d	Phys	9 Unknown								
00	res tha signed	d by		S Mell. Fus	resulting in the ur	idenying cause g	iven in Part I.				the cause of death? Trobably 4 Unknown
S.	v requir	olete	Hypertension 24a. Was an autonsy						s an	24b. Were au	topsy findings available
F	The law ate has	Ĕ	autopsy performe						formed?	prior to completion of cause of death? No 1 Yes 2 No	
7	clan: clan:	Be	25. Was case referred to medical examiner?	Hospital: X			Place of Death (Chec				710
7	Physi r this c eral dir	<u>و</u> 1	1 Yes 2 No 27. Manner of Death	1 L1 Inpatient 2 28a Date of injury	ER/Outpatient 28b. Time of	28c. Inju	ry at	g Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
1	ending sath. or: Afte	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No			k?				
9C #	DIVISION OF WIGHT RECORDS, F.C. BOX 00100. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The completely filled in by the funeral director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - A	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
•	Hospita 24 hours Funera etely fille	Medical (29a. Certifier (Check Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								cause(s) and manner stated.
	To the within To the comple	Σ								use(s) and manner as stated. Date signed (Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIYAH VESKEL MD Sing Haspital of Bulkimore					丁.	ly 10	2012	
17			30. Name and address of person who ARIYAH VESKE	440	tem 23a) (Type, Pi	Hero.L.	of RIL	More		′	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig		Juspirel	1)6/1/2	7-/V- C			
	Registr	ar	JUL 262	012	1 1	and d					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:25 AM SWIT JULY Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death COUNTY GENERAL HOSE Howard HOW ARD COLUMBIA, MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Pay, Year) 946 1 🛛 M 2 🗆 F Hours Min Director 512-46-4500 Ohio 65 Dec Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No SC Pickens Clemson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 29631 106 Riggs Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? "natural", or þ 1 Never Married 2 Married XYes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Caucasian Completed 3 Divorced 4 Divorced Year or Dates. 1972-72 other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) University 5+ Professor and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Dolores Scott Richard Arthur Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clemson, SC Henry / Wife 106 Riggs Dr. 29631 Joan W. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) nal Journey Crematory 7/25/2012 Woodbine, Maryland 21. Signature of Funeral Service Licenses MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the obsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Poset and Death Immediate Cause (Final disease or condition paucreatic Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence o): burial-tran resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be exby Physician/Medical Box 68760 the. attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

Companies a time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d Records, Completed 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division after death. Accident 2 Accider
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi D56399 son who completed cause of death (Item 23a) (Type, Print) ledarlane Columna, UD HCGIT 3255 32 Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Edgar Hopkins 2. Date of Death 3. Time of Death Physician/ Month 1:00 07 201 Medical 4a, Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b City Town or Location of Death MARIBLE 4506 40 BALTIMORE 8. Date of Birth (Month, Day, Yeune 23, 1 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) 78'rs Director 37-44-947 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore MD Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 4506 Marble Hall Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Divorced Year or DateAirForce 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Technical Sergeant AirForce other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file afth and Mental F Henry Hopkins 2 Ethel McDuffie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1040permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or are 308 Lord Willoughby's Way, Edgewood, Md. Sharon Hopkins (daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State July 27,2012 21244 Balto, Md. King Mem.Pk. 4 □ Donation 5 □ Other (Specify) Mausoleum 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 412 Balto, Md E. Preston St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final CARDIAC Onset and Death Physician/ VSRHYTHMIA 2008 disease or condition Medical resulting in death) Examiner ARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 4 Pregnant at time of death 9 Unknown Yes 2 No ed by the a 9 Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗆 No 1 🗌 Yes Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at NA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending NIA 1 🗌 Yes 2 🔲 No Investigation B Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined N A Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 07-23-2012 completed cause of death (Item 23a) (Type, Print) DRIVE. BALTIMORE MD 21211 3100 WYMAN SROWN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5,9,10e&f15,16A&BPer ANA BD G929 7/26/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ CARRIE LEE JUSTUS 11:35PM July 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** ecurity Number ttp 6. Sex 7. Age (In yrs. last birthday) Hours Min 74 229-44-1950 1 🗆 M 2 🗗 Director Virginia March 17, 1938 Usual Residence of Decedent chow 10c. City, Town or Location unk permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County unk Director unk 1 Nes 2 No MD 10e. Street and Number 41114 10f. Zip Code unk 10g. Citizen of What Country? Funeral USA 4300 zircon RD 21769 unk 12. Was Decedent Ever in U.S Armed Forces? **un** k 1 ☐ Yes 2 **XX**o If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. white þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3XX Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation un K-16b. Kind of Business/Industry unk 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 unk cashier retail -unk-Be 18. Mother's Name (First, Middle, Maiden Surname) - unk 17. Father's Name (First, Middle, Last) -unk-ပ Dorothy Lee Foster John Jesse Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 7th St; Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Frederick Memorial Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Simulture of Freeral Service Scene Wade Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MULTI ORGAN Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** I So HEMIC Sequentially list conditions, Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed burial-transi Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death ed by the at detached f been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s certificate funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 ☐ Yes 2 🗷 No 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 24 hours after death. Funeral Director; A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) mpleted cause of death (Item 23a) (Type, Print) Name and address of pe nederick MD Date filed (Month, Day, 32. Registrar's Signature State 26 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Joseph Jablonski 2012 Medical Facility Name (if not institution, give street and number) 4c County of Death **Examiner** ALI, MEDICAL U If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min. (Month, Day, Year, 76 220-32-3057 **Director** 1 XM 2 □ F Maryland July 4, Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 XNo White Marsh MD **Baltimore** 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral USA 21162 6039 Loreley Beach Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry d Mental Hygiene. marked other than ' life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 1ithography pressman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ပ Helen Kosinski Frank Joseph Jablonski any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6039 Loreley Beach Rd; White Marsh, MD 21162 Augusta Jablonski - wife Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) of Funeral Service Licens 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause in action in a Approximate Interval Between Onset and Death 8 Hours Immediate Sause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE res, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe completely filled in by the funeral director, page 2 2 × No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ျ 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 📉 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 07/22/2012

State Registrar 's Signature

DRIVE TOWSON, MD 21204

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 23721 State of Maryland / Department of Health and Mental Hygiene Thomas Jefferson 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical 3. Time of Death THOMAS **JEFFERSON** Examiner 0555 hrs July 20, 2012 4a Facility Name (if not institution, give street and number) 4b City Town or Location of Death County of Death Takoma Park Washington Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or Foreign **Funeral** Country) VA Months Davs Hours Min Director 227-62-8808 07-11-1948 2 F Usual Residence of Decedent 10c. City, Town or Location any 10a. State 10d Inside City Limits Fairfax MONTCOMERY RESTON or 28a-f show 1 Yes 2 X No ai", or items 23a or 28a-f shoviner must be notfiled at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Eventaner must be marked as event injury or other traumatic event, the Medical Eventaner must be marked as event. Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country 1907 RAMSTEAD LA. 20191 USA Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married White, etc. 1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specity: Specify: BLACK 2 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Executive Directive U.S. STATE 5± 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Be THOMAS JEFFERSON. SR. FANNIE RUFFIN ဥ 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGORY L. JEFFERSON/SON 6727 16TH , N.W., WASHINGTON, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Conation 5 Other Specify SURRY LANE 7/26/12 PETERSBURG, VA Signature of Funeral Service License 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. INC -0 1701 LAURENS ST., BALTO., MD 21217 Raft I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical W UNPENDED signed by the attending physician be detached for use as the burial #10h,20a,perFH,23a,27,perME,G932,10/2/2012,WS Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Yeer Fetal death nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o è 1 Yes 2 No 3 Probably 4 X Unknown Completed Records, has been : 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? 1 X Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital fo the Hospital or Attending Physician: Be examiner? Other Nursing Home 5 Residence 6 Other 1 Inpatient 2 X ER/Outpatient 3 DOA this 1 X Yes မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: e Funeral Director: etely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be 3 Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) OGME O.C.M.E. July 21, 2012 Assistant Medical Examiner Theodore M. King, Jr., MD 900 W. Baltimore Street, Baltimore, MD 21223 State

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 ar Physician/ July 14, Ruth Τ. Johnson . Medical :532 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12705 Whiteholm Drive Upper Marlboro Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs **Director** 578-22-6422 1 M 2 F Aug.13,1921 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD PG Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? Funeral 12705 Whiteholm Drive 20774 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 承Widowed 4 ☐ Divorced Specify: Completed Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AT&T Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy Easley Mamie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12705 Whiteholm Drive Upper Marlboro, MD. 20774 Portia Tyler/Daughter Upper Mar 20b. Place of Disposition (Name of 20a. Method of Disposition 7/23^{Date} 7/23/12 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Quantico Nat. Cemetery Triangle, VA re of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland,MD.20746 23a. Part. Enter the disease, or complications that dauked the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition PHENTIO Medical resulting in death) a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Lisease or injurthat initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year filled in by the funeral director, page 2 should be detac. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No Accident Investigation hin 24 hours after death the Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melanie Bennold 31. Date filed (Month, Day, Year)

2 6 2012

ANP-B

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month ernice Jackson 0347AM ul Medical Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death General Dorch HOSPITA ambrida orchester If Under 1 Year If Under 24 Hs. 8. Date of Birth
Months Days Hours Min. Month, Day, Year

2 7 - 1 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Many) 6 **Director** Usual Residence of Decedent 10a. State 10b. County 34 10c. City, Town or Location 10d. Inside City Limits Director notified Dorcheste 28a-f Maryland Vienna 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 76 Old Route 21869 United Sitates 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc 1 Never Married 2 Married ò If Yes, Give Year or Dates 1 Yes 2 No 3 Widowed 4 Divorced Specify: Completed Black Baltimore, Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Solo abover Be 17. Father's Name (First, Middle, Last) မ Walle, Kichard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherwood Lea Jackson Jouse Route So 4876 Old (/ienna 20b. Place of Disposition (Name of 20a. Method of Disposition 302012 Huslock July 21. Signature of Funeral Service Licensee Name and Address of Facility CALUIN L WILLIAMS 1913 Robin Laje 2 Low 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final etasta Physician/ ancreate disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death Day signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatu and title of certifie License number 043238 24,2012 30. Name and address of person with completed cause of death (Item 239 (Type, Print)) 0 Cambridge, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			Please		rint in Black			-	_	jible.
			For State	State of N	Maryland / De			∕lental Hyg	giene	112 23724
			Registrar 1. Decedent's Name (First, Middle, Las	et)	C	ertificate of l	Death		Reg. No. C	
i.	Physician/ Medical JOSEP h				Kenny					Year 10:20 A, M,
	Exami	4a. Facility Name (if not institution, give street and number 607 Lakeland Road South					r Location of Death		4c. County	of Death Arundel
·	Funeral		5. Social Security Number 6. S		ge (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Director			∑ M 2 □ F	88 Yrs.	Months Days	Hours Min.	(Month, Day,		Country) Maryland
	show	5	Usual Residence of Decedent 10a. State 10b. County	l	10c. City, Town or	Location		Aug 3,	1923	10d. Inside City Limits
	Maryla 28a-f s etified	rect	MD Anne A	runde1	Sever	na Park				1 ☐ Yes 2 🛣 No
	with the s 23a or 3 ust be no	Funeral Director	10e. Street and Number 607 Lakeland Ro	ad South		10f. Zip Code 21146			10g. Citizen of V USA	What Country?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Ma <i>rr</i> ied 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 12 Yes 2 If Yes, Give Year or Dates.	? 10/2	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, kk, White, etc. white
Baltimore, Maryland 21215-0036	vithin 72 hou iene. ir than "natu the Medical	Completed by	15. Decedent's E (Specify only highest grant properties) Elementary/Secondary (0-12)		(Giv 15+)	cedent's Usual Occup re kind of work done DO NOT use retired) Ontractor	during most of work	ing	16b. Kind of Bu	unk unk
yland 2	uld be filed v I Mental Hyg narked othe natic event,	To Be	17. Father's Name (First, Middle, Last) Stephen Kenny				18. Mother's Name Anna Di		Maiden Sumame	3)
e, Mar	permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mai any injury or other traumat once.		19a. Informant's Name/Relationship (7) Linda A. Kenny		er 5	iling Address (Street 703 Frank)	and Number or Rura Lin St; Br	al Route Number,	Park, M	D 21225
timore	Page 1 a tment of F tant: If ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specil	y)	e cemetery, cr	position (Name of ematory or other plac	ce)	Date		City or Town, State
Ba	Depar Depar Impor any in		21. Signature of Funeral Service Licens Ronald S	Wade, Di	rector	22. Name and Addre	ss of Facility Sta Baltimore	St; Bal	omy Boan timore,	MD 21201
	Physician/ Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each li	Den	enter the mode of dyin	ng, such as cardiac c	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b	s a consequence of):					
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
09/	cate be ex physician the buria	<u>a</u>	L	d						
. Box 68760	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	Ctopic pregnand Other (specify)	cy		23d. Dat Moi	te of delivery nth Day Year
s, P.O.	requires that the death been signed by the atte should be detached for	d by P	Part II. Other significant conditions co	ontributing to death	but not resulting in the	underlying cause gi	ven in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
Record	The law requate has beer page 2 shou	Completed by			•			24a. Was ar autops perform	med? _ d	Nere autopsy findings available one of completion of cause of leath? Yes 2 No
E	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Pl	ace of Death (Check		2 - No 1	Tes 2 INO
Ξ	Physic this ce ral dire	မ	1 ☐ Yes 2 ☐ No		tient 2 ER/Outpati		er: 4 Nursing Ho	me 5 Reside	ence 6 🗆 Othe	er (Specify)
n of	Attending Physician: r death. sctor: After this certific by the funeral director,	ate	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of inj (Month, D	ury 28b. Time ay, Year) injury	work	yat ⟨? Yes 2 No	28d. Describe ho	w injury occurre	ed
	i i i i	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, farm, s tc. (Specify)			28f. Location (Sti City or Town		er or Rural Route Number,
	the Hospital or thin 24 hours afte the Funeral Dir mpletely filled in	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of	of my knowledge, death examination and/or inve he best of my knowledg	estigation, in my opinio	on, death occurred at	the time, date and	d place, and due	to the cause(s) and manner stated.
	P V V V		29b. Signature and title of certifier	J 250	Entre	29c. License	e number) V1438	2	9d Nate signed	(Month, Day, Year)
_			30. Name and address of person who	ENTAI	n 445	Print) Out	Inse 14	wy as	mapa	lis, Mrd. 2144
	Sta ^r Registra	וכ	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	es !		1	9	/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Irvination Future Care 8. Date of Birth (Month, Day) If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral S. Carolina 1 M 2 □ F Months Hours Min. 72 54 4988 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Wadical Evarrant or other traumatic event, Ita Wadical Evarrant or other traumatic event, Ita Wadical Evarrant or other traumatic event, Ita Wadical Evarrant or other traumatic event, Italy events once. 1 Yes 2 No Director MD NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? North AVE 2320 21216 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical iOth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kell Flosie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clevelana Konnie Kelly 4234 E. 1284 St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Catorsville, mo Metro Cremator 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Funeral Service Line place 22. Name an Address of Facility Bary P. March FH & 70 Fredhillon Pass Bauto. mo 21229 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE Approximate Interval Between Onset and Death **P**hysician /Medical Due to (or as a consequence of): Examiner ulmonary HROBIC OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed ANEMIA sician and burial-trans Due to (or as a consequence of): Box 68760, the attending physician ned for use as the burial ARDIOMYOPATHY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed? 1 □ Yes 2 No certificate 2 🗆 No 1 ☐ Yes te Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (my -19-2012 071264

Registrar

DHMH 17 Rev 1/2001

State

AVENUE

BALTIMORE, MD 2122

S.ATHOL

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UZO UNEGBU, MI)

JUL 2 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	Maryland /		artment tificate					2012	23	727
			Registrar 1. Decedent's Name (First, Middle, L	.ast)		001	incato	07 0000		2. Date of De	Reg. No. ath		3. Time o	f Death
п	Physicia Media		Barbara Langley	7						Month	Pay 17	2012	9:20	AM
and a	Examir		4a. Facility Name (if not institution, g)			own, or Locat		1	4c. Co	ounty of Death		
400	C		Union Memorial 5. Social Security Number 6		Age (In yrs. last bir	rthdav)	Ba.	1timor	e nder 24 Hrs.	■ 8. Date of Bir	th	9 Birthi	place (State o	or Foreign
	Funeral Director		220-74-9012 Usual Residence of Decedent	1 □ M 2 🏋 F	55	Yrs.		Days Hou		(Month, Da	y, Year)	Cour	try)unk	or r Groigh
	fand f shov	ţo	10a. State 10b. County		10c. City, Tow							-	0d. Inside C	
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	with the	Funeral [10e. Street and Number 2095 Rockrose A	Avenue			10f. Zip C	1211			USA	n of What Coul	ntry'?	
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21215-0036	ed within 72 hou Hygiene. other than "natu ent, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) unk			(Give I	dent's Usual (kind of work) O NOT use re	done during	ink most of wor	king	16b. Kind	of Business/In	dustry un	k
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Maryland	shouth and it is in traum	T T	19a. Informant's Name/Relationship Violet Durst		19	b. Mailir	ng Address (S	Street and No	umber or Ru	ral Route Numbe	r, City or To	wn, State, Zip (_{Code)} unk	
Baltimore,	Page 1 and 2 ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🛣 Other Spe		ate cemete	ery, cren	sition (Name natory or oth	er place)		Date		ation - City or Te	own, State	
Balt	permit. Page Department of Important: If any injury or once,		21 Sign 1 re of Funeral Service Lice	ane Dir	ector	22				ate Ana St; Ba	_		21201	
1	Physician/		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	y one cause on each I					/c	or respiratory ar	rest, XFOLIA -PUPTI	TIVE 3	Approxima Interval Be Onset and	ween
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	Hospita 4 hours Funeral tely filled	Medical	(Check 2 L Medical Exa	hysician: To the best aminer: On the basis of lurse Practitioner: To	of examination and/	or invest	tigation, in my	y opinion, dea	ath occurred	at the time, date a	and place, ar	nd due to the ca	luse(s) and ma	anner stated.
	To the I within 2 To the I complex	-	29b. Signature and title of certifier	le	MN		29c. l	License num	ber		29d. Date s	signed (Month,	Day, Year) 201	2
			30. Name and address of person with DIMITPA MI	TSAN LA	f death (Item 23a)	(Type, F		UNIVE	esity	PRICE'S	/ 21	218 M	b	
	Sta Registr		31. Date filed (Manth Day Year)	12 Lenn	strar's Signature	ber	Keel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 08 PM Theresa A. Lang Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Kusedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min Months Hours March 7, 1957 218-72-8640 55 MD 1 □ M 2 🔀 F Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Middle River Baltimore MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21220 Seneca Road 1131 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) CCBC Supervisor Custodial 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. ပ Albert Griffith Helen Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1131 Seneca Road Baltimore MD 21220 19a. Informant's Name/Relationship (Type, Print) Louis W. Lang /husband 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Bayview Crematory 7/30/12 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 8 1 Other (Specify) Ave Balto MD of Essex 21221 Junial Ser 22. Name and Address of Facility Mace Home 300 Connelly Funeral 23a. Part 1. Enter the disease, or compositions of shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final tallura Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events and Due to (or as a nsequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page 2 this certificate 2 No or Attending Physician: after death.

Director: After this certifications filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:45PM Percell Locklear Jr. Physician/ JUL 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** ROSEDALE BALTIMORE HOSPITAL *LRANKLIN* QUARE Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) Months 215-60-0013 1 🛛 M 2 🗆 F 57 March 18,1955 Director Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Directo Md. Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 Queens Purchase Apt. C 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 X Married ģ White 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Glass 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Anderson ည Percell Locklear Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Md. 21221 Deborah Locklear Wife 1111 Queens Purchase Apt. C 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of July^{Dat}27, 2012 cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 o complications that caused the death conot enter the mode of dying, such as cardiac or respiratory arrest, to my one cause on each line. 23a. Part 1. Enter the disease, of shock, or heart failure. List Onset and Death Immediate Cause (Final Physiciany MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** DIABETES Sequentially list conditions, cause. Enter Underlying Exami certificate be executed Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?

1 Yes 2 No The law requires that the death Month Year Pregnant at time of death Day signed by the at Id be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral II

completely filled Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 00071830 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 AZHER MERCHANT 31. Date filed (Month, Day, Year) State 32/Registrar's Signature

Registrar

2 6 2012

amend #7, per fh. g930 8-2-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #/ Per FH g929 7/26/2012 JH State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 21^{ay} 2012 7:02 A RUBY LAWRENCE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Largo Prince George's Manor Care of Largo Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Hours Min (Month, Day, Year) 100 **Director** 1 🗆 M 2 🗓 F 240-14-1337 08/22/1912 North Carolina Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location Maryland must be notified at 10d. Inside City Limits Director 1XXYes 2 No Upper Marlboro MD Prince George's the 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 20772 USA 4706 Colonel Ewell Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗡 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify:Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Beautician 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Althermeris duease ည Eliza Mason Horace Whitaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706_Colonel Ewell Ct. Upper Marlboro, MD 20772 Ruth Driver/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Northeastern Cemetery 07/28/2012 Rocky Mount, NC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Marshall-March Funeral Home 22. Name and Address of Facility 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Alzheimer Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Diabetes Mellitus and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 as the t IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 24 has page 2 certificate 1 🗌 Yes 2 🔀 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ₩ No Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 😾 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this fune al 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? death. 2 🗆 No Accident Investigation within 24 hours at er deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu title of certific 29c. License number 29d. Date signed (Month, Day, Year) WVY D 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, MD 1328 Southern Avenue SE Washington, DC 20032 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Levine, Alfred Connie

			Please	Type or Print in B				_		_	
		-	For State	State of Maryland		irtment of H <i>tificate of D</i>		nd Mental H		201	2 23731
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	incate of b	- Calli	2. Date of D	Reg. No eath		3. Time of Death
	Physicia Medic		Alfred Connie	Levine				July	124	2017	2 9:35AM
	Examin	er	4a. Facility Name (if not institution, give s	medical Ce	NOC	4b. City, Town, or	Location of E	Death	40	County of Dea	ath CC
	Funeral		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E		9. Bi	rthplace (State or Foreign
b	Director		214-64-0633 Usual Residence of Decedent	MM2□F 5	6 Yrs.	Monard Baye	110010	08/12	1/195		Md
	/land f show ed at	tor	10a. State 10b. County		Town or Loc				,		10d. Inside City Limits
	or 28a- notifie	Direc	M D 10e. Street and Number	D	alti	nore 10f. Zip Code			10g Cit	tizen of What C	1 ★ Yes 2 No
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	death ritems iner m		11. Marital Status	 Was Decedent Ever in U.S. Armed Forces? 	13. V	/as Decedent of His Yes, specify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	D-	14. Race - Am-	
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212	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5+)	.//	NOT use retired)	Tech	'	Jo	HN H	OPKINS
	e filed ratal Hyged of other event,	To Be	17. Father's Name (First, Middle, Last)				_	Name (First, Middle Ner Nes		Surname)	
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_	nd 2 sh ealth a m 27 is ner tran		Natosha Levine		4610	Moravi	a Rui	Way . F	Balto	, MD.	21206
Baltimore ,	ige 1 a nt of H t; If ite		20a. Method of Disposition 1 PBurial 2 Cremation 3	Removal from State	metery, crem	atory or other place	e) _	7/30/12	20c. Lo	ocation - Uity o	r Iown, State
altin	permit. Page 1 Department of Important: If i any injury or once.	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of unera Service Licenter)		22.	Cemeter Name and Address	of Facility	VAUGHN	GREG	ENE FUL	VERAL SONS
ä	permi Depar Impor any ir		1000	MO1553	4	905 Yor	K Roa	id. BM+	MOr	e, Md	. 21212
	-		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final		Do not ente	r the mode of dying	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Pnysician/ Medical		disease or condition resulting in death)	a. Due to (or as a conseque	nce of):		_				2-Days
	Examiner	-	Sequentially list conditions,	Gastroin	resti	nal ble	ed				1 Day
	rted d ansit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	On acreat	nce out	ancec	pris				Vens
	executed ian and urial-transit	l= 1	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
200	ath certificate be attending physici. for use as the bu	edica		d							
Box 68760	ending onding	M/ne	200. Was decedent pregnant	3c. If yes, outcome of pregnand		Ectonic pregnanc	27			23d. Date of de	elivery
	requires that the death been signed by the attershould be detached for	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de		Other (specify)				Month	Day Year
Division of Vital Records, P.O.	that the	by Ph	Part II. Other significant conditions co	ntributing to death but not resul	ting in the u	nderlying cause giv	ren in Part I.	23e. Dio	I tobacco ι	use contribute t	to the cause of death?
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VIt	Physicia this cer ral direc	유	1 L Yes 2 No	lospital: 1 🔀 Inpatient 2 🗆 E		t 3 🗆 DOA Othe	er: 4 🗌 Nurs	ing Home 5 🗆 Re	sidence 6	〕 ☐ Other (Spe	ecify)
n of	iding P th. After t funera	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1 \square		28d. Describe	how injur	y occurred	
/isio	r Atten ter dear rectors by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Location	(Street and		ural Route Number,
ă	pital or		29a. Certifier 1 Certifying Phys	ician: To the best of my knowle	dae deeth e	acurred at the time	data and al	4			ptated
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2 Medical Examin	er: On the basis of examination as Practitioner: To the best of my	and/or invest	igation, in my opinio	on, death occu	irred at the time, date	and place	e, and due to the	e cause(s) and manner stated.
	To th To th		29b. Signature and title of certifier	0000 10	0	29c. License	_			te signed (Mon	
	9		30. Name and address of person who co	empleted cause of death (Item 2	23a) (Type, P	rint)					
			Linda adler	M.D	7	1601081	eri	orive Tr)WS	onmi	21204
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re						
			/	, , ,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July Physician/ 2012 1:43 P M Lewis Robert James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Columbia Gilchrist Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Min (Month, Day, Year) Days Hours 219-26-7577 1**X** M 2 □ F **Director** May 1, 1938 Maryland 74 Usual Residence of Decedent i show 10d. Inside City Limits 10c. City, Town or Location 10a, State notified at Director 1 X Yes 2 No 28a-f Volusia Port Orange FL10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r ō Funeral United States 32128 2030 Taylor Road er than "natural", or items the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. by 1 Never Married 2 Married 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1956-58 White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Auto Dealership Owner 27 is marked other r traumatic event, t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Helen Umbaugh Cooper John Lewis, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Woodbine, MD 21797 James Lewis, Jr./Son 2425 Daisy Rd. Robert : If item 2 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 Department of I Important: If it any injury or o ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 7/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Lices MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Mycloid Physicass/ disease or condition resulting in death) Medical Due to (or as a cons (quence of) Examiner Securetially list condition Examine if any, leading to immediate cause. Enter Underlying Due to or as a consequence of): Cause (Disease or injury the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran that initiated events ding physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by been signe should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe 1 Yes 2 KNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? 1 ☐ Yes 2 🗶 No Other: 4 Nursing Home 5 Residence 6 M Other (Specify) Hospital: Hospice 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural After injury 5 Pending 1 🗌 Yes Accident Investigation within 24 hours after death

To the Funeral Director:
completely filled i⊨ by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one)

State

Registrar DHMH 17 Rev 06-2011 29b. Signature

Q. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CEDAR

Registrar's Signaty

ABBAS

LANE

29c. License numbe

D72139

COLUMBIA

29d. Date signed (Month, Day, Year)

2104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Deced t's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month 9100 AM 70 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Howard Howard County General Hospital Columbia Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F (Month, Day, Year) ar 29, 1922 Days Hours Min. Director Colorado 549-32-4544 90 Mar Usual Residence of Decedent or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Columbia MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21044 United States 5400 Vantage Point Road #903 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 4 Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of ပ Martha Holmes William L. Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 7964 Brightlight Place Ellicott City, MD 21043 Snyder / Daughter Nancy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 7/28/2012 Woodbine, Maryland permit. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Box 68760-C Physician/Medical as the t IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months
1 Yes 2 No Month Year Pregnant at time of death signed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b pothyrvidism 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 410 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0071233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print OWARD County General Huspill TSADIK Date filed (Month, Day, Year) Registrar's Signature State 26 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NaThan 0 009 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brilling re 171901E If Under 8. Date of Birth, 9. Birthplace (State or Foreign **Funeral** Country) Months Hours Min (Month Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country 10e. Street and Numbe Funeral 20 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle 2 Nathaniel permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic traumatic Informant's Name/Relationship (Type, Print) Bural Route Number, City or Town, State, Zip Code Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of - City or Town, State Date 20c. Location 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, cremator other pla -innamon 21. Signal Funeral Service Licensee M) 21216 5 more 23a. Part 1/2 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ NYUN Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated even in the conditions of the con Exami burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical e Hospital or Attending Physician. The law requires that the death certificate be 24 hours at ler death.
E4 hours at ler death.
Funeral Director. After this certificate has been signed by the attending physicial letter filled in by the funeral director, page 2 should be detached for use as the burneled filled in by the funeral director. P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: 1 Natural injury 5 \square Pending 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title certifie 29c. License number

Registrar

State

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MOTTIS

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Marshald 8027420121 JH Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 5 tanley B Physician/ Month 07 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Medical Center 01ney Social Security Nu8927 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Days Months Hours Min. (Month, Day, Year) Director 217-12-8929 87 1 □**X**M 2 □ F Yrs Usual Residence of Decedent Dec 9, 1924 Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Woodbine 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Page 1 and 2 should be filed within 72 hours after death with i ment of Health and Mental lygiene. The trians 13 a ment of Teath and Mental lygiene. The matural", or items 23 a world file mental or or other traumatic event, the Medical Examiner must be ury or other traumatic event, the Medical Examiner must be by Funeral 16325 Frederick Rd. 21797 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) builder construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Robert Miller Jesse Mae Goode 19a. Informant's Name/Relationship (Type, Print) Stnaley Miller Jr. - son 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Konalo S. Wade 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Severe Preumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): Exami ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be evithin 24 hours after death.

To the Funeral Director, After this certificate becompletely filled in the completely filled in the com Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? encephalopathy Completed by Arter this certificate has been si funeral director, page 2 should it 1 Yes 2 No 3 Probably 4 Unknown Endstage Renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No ည Other: I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number Emmvel Kokotakis, MD 22/12 MD-D56030 Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emanuel J. Kokotakis 7601 Osler Drive Towson, MD 21204 31. Date filed (Month, Day, Year, JUL 26

State Registrar 2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		- FOI	Maryland / Depa			lental Hygien	2012	23736
		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Death	Reg. No.).	3. Time of Death
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/Medi Exami		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Death		County of Death	7.0
		12800 W Wilson Rd	(Homz)	Hints	stone,	md	A11890	
Funeral		- 10/11 of t	Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.' Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthr Cour In	place (State or Foreign http) diana
Director		Usual Residence of Decedent	46 Yrs.			10-30-1	770 111	urana
ryland how	_	10a. State 10b. County	10c. City, Town or Lo	1 .1			1	0d. Inside City Limits
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death with the Maryland ims 23a or 28a-f show r.must be notified at	nera	11 Marital Status 12. Was Decede	nt Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
5-UUSO 72 hours after natural", or ite	by Funeral Director	Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	No	If Yes, specify Cuba 1 □ Yes 2 No	Specify:	nicall, etc.)	Specify: White,	7ite
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/land uld be file Mental Hy arked oth	To B	Richard Frederick Michel				ce Barbara		
Mary nd 2 sho alth and 2 27 Is me or traums		19a. Informant's Name/Relationship (Type. Print) Teresa Ann Michels — Wi		ng Address (Street 800 W. Wi	and Number or Run 1son Rd;	al Route Number, City Flintstone	or Town, State, Zip , MD 2153	3 Code) 30
BAITIMOTE , Maryland ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrairer must be notified at any once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date 20c. I	ocation - City or To	own, State
Danti permit. Departi Importa any inju		21. Signature of Funeral Service Licensele Ronald S Wade Di				ate Anatom St; Balti		21201
		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	h line.			or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	assatic Co	olow Ca	ncer		F	Onset and Death
/Medical Examiner		resulting in death) Due to (or	as a consequence of):					1
± 0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):					
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&/oU, cate be ex physician the burial	a E	bue to (or	as a consequence or.					
567 ifficate g physas the	edical	d						
death certifi de attending ed for use as	M/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco		☐ Ectopic pregnanc	ev.		23d. Date of deliv	
COrds, F.O. BOX by wrequires that the death certific sheen signed by the attending should be detached for use as	Physician/M		nt at time of death 5	Other (specify)			Month	Day Year
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Kecords, he law requires t e has been signe ige 2 should be c	Completed					24a. Was an autopsy		opsy findings available ompletion of cause of
— ⊢ — bat	Som					performed?	death?	2 ³ ØNo
OT VITAI Physician: Trithis certificat	Be	25. Was case referred to medical examiner? Hospital:		Oth	or:	h (Check only one)		
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ION arth. r: Afte	atior	1 Accident 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day, Year) Injury	M 1 🗆	k? Yes 2□No			
DIVISION I or Attending after death. I Director: Afte	Certification: To	3 Suicide 6 Could not be determined 28e. Place of building	Injury - At home, farm, st , etc. (Specify)	treet, factory, office		28f. Location (Street a City or Town, Sta		al Route Number,
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dil	Medical C	29a. Certifier Certifying Physician: To the brushes one) Medical Examiner: On the bas and manne	is of examination and/or it					
To the Youthin To the Complement	Me	29b. Signature and title of certifier		29c. Licens	se number	29d. E	Date signed (Month	-
		> HmaScatul MD		144	0346		7/16/12	
		30. Name and address of person who completed cause			21500			
s. S	tate	Huma Shaki1. 625 Kent 31. Date filed (Month, Day, Year) 32. Reg	Ave. Cumber jistrar's Signature	erland,MD	21502			
Regis		31. Date filed (Month, Day, Year) 32. Beg	we B. A	are				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25, PER ME G929 7/25/12 TRT

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Harold L. Mallow Physician/ July 2012ª 10° 13:45 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford County Examiner 4b. City, Town, or Location of Death Harford Memorial Havre de Grace Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-38-2196 Ye 1942 70 March 22 West Virginia Yrs Director Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Maryland Harford County Street 1 Yes 2XX No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o 105 Davis Road 21154 United States 12. Was Decedent Ever in U.S. Agned Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Capital Carbonics Salesman 1 and 2 should be filed wi of Health and Mental Hygic item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Mallow Nellie Shirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Traci Offidani (Dauchter) 50 Davis Road, Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Manorial Cardens 07/13/2012 permit. Page 1 a
Department of F
Important: If ite
any injury or ott
once, 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services - Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY FIBROSIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner KIDNEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to lor as a consequence of signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Vear 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed death? Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medica examiner? Division of Vital Be 26. Place of Death (Check only one) 1 XYes 2 10 Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director, After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier D0069118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 Revolution Street House de Groce, MD 21078 Puthawala State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 2.3.27.28a-f. per me of 931 the state of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Evangeline Murphy July 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury 320 Delaware Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Min 82 218-24-5704 Usual Residence of Decedent 1930North Carolina March 11. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Wicomico Salisbury 10e. Street and Numbe. 10f. Zip Code 10g. Citizen of What Country? 21801 USA 320 Delaware Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Isam Murphy Harriett Cherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 320 Delaware Ave; Salisbury, MD 21801 John Murphy - brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔲 Burial 2 🗍 Cremation 3 🗍 Removal from State 4 X Donation 5 Other (Specify) 21. Signature Funeral Service Licens Romald S. Wide, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence oi). Due to (or as a consequence of): 23c. If 23b. Was decedent pregnant livery in the past 12 months?

1 Yes 2 No
9 Unknown Day Year

Physician/ Medical Examiner

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Hospital or Attending Physician:

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

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Examiner

Funeral

Director

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permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

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IF FEMALE:

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yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death	3
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otopic pregnancy	23d. Date of de
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26. Place of Death (Check only one)

Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part

23e. Did tobacco use contribute to the cause of death?							
1 ☐ Yes 2 [No 3 ☐ Probably 4 ☐ Unknown						
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						

25. Was case re examiner?	eferred to medica
27 Manner of I)eath

	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	281
ion	fd 7-8-12	u

Outpatient b. Time of		28c	Injury at	☐ Nursing H	28
injury		200.	work?		S
nk	М		1 Tes	2 X No	ei

5 Residence 6 Other (Specify)	
Describe how injury occurred biect exposed to h	ıi

1-Notural	5 Pending
2 Accident	Investigation
3 Suicide	6 Could not be
4 Homicide	determined

fd	7-8	-12	unk	М	1
28e. F	Place of I building,	njury - At ho etc. <i>(Specif</i>)	ome, farm, : /)	street, facto	

subject exposed to high environmental temperature
28f. Location (Street and Number or Rural Route Number City or Town, State) 320 Delaware Avenue Salishury MD

			DULLED	/ /
9a. Certifier	1 Pertifying Physicia	an: To the best of my knowledge, death occurr	ed at the time, date and place, and due to the	cause(s) and manner as stated.
(Check	2 Medical Examiner	: On the basis of examination and/or investigation	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stat
only one)	3 LCertifying Nurse P	ractitioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
b. Signature	nd title if certifier		29c License number	20d Date signed (Month Day Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a&b Per FH G929 7/26/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ROYSTON CORDELL Month MADARY 14:17 23 201 100 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL INSPITAL COLUMBIA HOWARD 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 220-18-7801 Director 1 XM 2 □ F 86 06/01/1926 Usual Residence of Dece 23a or 28a-f show 10a. State Maryland 10b. County 10c. City, Town or Location item 27 is merked other than "neturel", or items 23a or 28a-f sho other treumetic event, the Modical Experiment to motified at 10d. Inside City Limits Directo Howard 1 Yes 2 No 12040 01 Frederick Rd. Marriottesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12040 Old Frederick Rd 21104 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 S Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Electrician 8yrs æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Royston MAdary Louise Steingrass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Importent: If item 27 is any injury or other treu 10530 Cross Fox Ln. C-1 Columbia, Md. 21044 Kimberly A. Madary (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 107/27/2012 Crest Lawn MArriottesville, Md. 21. Signature of Furged Service Licensee 22. Name and Address of Facility Haight Funeral Home & chapel P.O. Box 195 Sykesville, Md. 21784 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Up only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MESPIRATURY AWTE disease or condition resulting in death) p.ry Medical Due to (or as a consequence of): Examiner 5 YEARS USSTRUCTIVE Prunumary CIMMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospitei or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END START NOWN DISENSE DOD EMBANI PIALLESS 1 Des 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 H i Director: After this certificand in by the funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No |<u>|</u>2 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours effer des To the Funerei Director completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the desired of the cause of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36974 De 23 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID am motivaryin. o 10710 CHARTER DRIVE #313 ms 21044 CRUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7/19/2012 Reginald Lee McGee 11:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A 727 N. Patterson Park Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) Director 214-64-2593 1 💢 M 2 🗆 F 55 Yrs. 1/4/1957 MD Usual Residence of Decedent or than "netural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director N/A Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 727 N. Patterson Park USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Il Hygiene. other than "netural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City 10th N/A Snow Removal Tech. Be permit. Page 1 end 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumetic eveni 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Anna Johnson Robert L. McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
727 N. Patterson Pk. Baltimore, MD 21205 Anna McGee-Mother Baltimore, 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Memorial Pk. 7/25/2012 Randallstown, MD King 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H- East 1101 E. North Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): الع carcinoma of Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ours after death.

leral Director: After this certificate hes been signe filled in by the funeral director, page 2 should be Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 X/N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 2 X No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BV Ni Charles ST TONSON MO CHARLES MD 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 6 2012 Registrar

DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 7:15 A M Terrance Joseph Marceron Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Columbia Howard Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 217-42-2246 **Director** 1 X M 2 🗆 F Yrs 67 Missouri Usual Residence of Decedent Aug 29, 1944 28a-f show 10c. City. Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 X Yes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5021 Eliots Oak Road 21044 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Home Improvement Elementary/Secondary (0-12) Sales Manager Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Norman Maceron Catharine Goetzinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Marilyn E. Evans / Wife 5021 Eliots Oak Rd. Columbia, MD 21044 Important: If item any injury 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 7/26/2012 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Signature of Funeral Service MO1251 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death TONGUE Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 09289 attending ph d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death ed by the a 2 No 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital ှင 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation To the Funeral Director: / completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21044 SYED ABBAS MD CEDAR COLUMBIA 6336 LANE 31. Date filed (Month, Day, Year) State 2 6 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darren William McIntyre State of Maryland / Department of Health and Mental Hygiene 2012 23742 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month **Medical Examiner** 2102 hrs July 14, 2012 Darren William McIntyre 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2223 Hudson Road Cambridge Dorchester 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** oreian Months Days Hours Min Director 08-21-1965 217-76-7368 1 XM 2 F Country) Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Ann Arundel Glen Burnie Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygere.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ro other trannatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Milton Ave 21061 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 X No Yes Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced Specify: White <u>و</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Heating and air Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 conditioning HVAC Tech 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) David McIntyre Donna Gladden McIntyre Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Milton Ave. Baltimore, MD 21061 Lori McIntyre / Wife 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Itimore, 1 Burial 2 X Cremation 3 Removal from State July 20,2012 Glen Burnie, MD Donation 5 Other Specify Atlantic Crematory 21 Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home 14Chatar > H01456 1328 Sulphur Spring Rd. Arbutus, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Dnset and /Medical Death a Multiple Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): g physician and the burial - transi Physician/Medical UNPENDED AMENDED IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year use as 1 Day past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown cate has been signed by the attu-Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. <u>გ</u> 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 No 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes ۵ No 28a. Date of Injury (Month, Day Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Jul 14, 2012 Driver pick-up truck fixed object collision 1 Natural 2050 hrs Division 1 Yes 2 ✔ No 5 Pending within 24 hours after death To the Funeral Director: filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2223 Hudson Road, Cambridge, MD determined (Specify) Major Road Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 15, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DOME Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Depedent's Name (First, Middle, Last, **Physician** lacion 2012 /Medical Town, or Location of Death County of Death Montgowe 2 Facility Name (If not institution, give street Examiner bethes da arriage 8. Date of Birth (Month, Day, Year) 11/25/1919 Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2□F Poland Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Intit if item 27 Is marked other than "natural", or items 23a or 28a-f show that if item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Florida Palm Beach Delray Beach 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33446 U.S.A. 15436 Strathearn Drive Be Completed by Funeral 12. Was Decedent Ever in U.S. Aymed Forces? 1∆ Yes 2 □ No 1942 − If Yes, Give Year or Dates: 1943 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. Baltimore, Maryland 21215-0036 White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Baby Furniture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mordichei Marjamtolski Sima Aueron ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8800 Bellwood Road. Bethesda. Maryland 20817 Lester Marion - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Park Cemetery 07/24/2012 Paramus, New Jersey 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner , Hospital or Attending Physician: The law requires that the death certificate be executed bours after death. burial-transit Atherosclerotic Vascular Disease Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cerebrovascular Accident 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe death? 1 ∐ Yes 2□ No 1☐ Yes 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: A in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

homas

Thomas Masterson,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

DHMH 17 Rev 1/2001

MD19875

6801 Whittier Avenue, Suite 200, McLean, Virginia 22101

July 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23744 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CLARENCE DELMORE MAYBERRY JULY 21 2012 5:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11202 ORLEANS WAY MONTGOMERY KENSINGTON 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birtholace (State or Foreign 1 X M 2 - F Months Hours WEST VIRGINIA Director 235-52-8404 AUGUST 19, 1936 Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County the Maryland Completed by Funeral Director 10d. Inside City Limits r 28a-f sh notified 1 Yes 2 X No **MARYLAND** MONTGOMERY KENSINGTON 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? must be with 23a 11202 ORLEANS WAY 20895 UNITED STATES Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 X Yes 2 □ No POST-Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", Specify: 3 X Widowed 4 Divorced Year or Dates. **-KOREAN** WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other FEDERAL GOVERNMENT AUDITOR Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic even မ DAVID PETER MAYBERRY DOROTHY ISOBEL AKERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i MELBA MCGLAMARY/ SISTER-IN-LAW 11202 ORLEANS WAY, KENSINGTON, MARYLAND 20895 20a. Method of Disposition 20b. Place of Disposition (Name of ROSELAWN Department of H Important; If ite any injury or otl Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State ŲLY 4 Donation 5 Other (Specify) 2012 MEMORIAL GARDENS PRINCETON, WEST VIRGINI 22. Name and Address of Facility ROBERT A. BETHESDA-CHEVY CHASE, INC. BETHESDA, MARYLAND 20814-Signature of Funeral Service Licensee PUMPHREY FUNERAL HOME/ . 7557 WISCONSIN AVENUE the Dan M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIO-RESPIRATORY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner AMYOTROPHIC LATERAL SCLEROSIS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): anding physician use as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery atten 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown signed by the at d be detached fo 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, SLEEP APNEA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death? this certificate 2 No Yes 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certificated filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify 27. Manner of Death 1 Katural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) #ME91750 JULY 23, 2012 T Mantell - VLUD

State Registrar 31. Date filed (Month, Day, Year) 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

ROBERT MARK KAISER, M.D., VAMC,50 IRVING STREET NW, WASHINGTON,DC 20422/688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2^{Day} Dorothy Roberta Massey 2012 07:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Aberdeen 481 Manor Road Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 8748719° 92 **Director** 215-58-4821 WV Usual Residence of Decedent 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Aberdeen MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21001 USA 481 Manor Road items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces ö δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 😾 Widowed 4 🗆 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) In Home Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Margaret Casteel Lloyd Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen, MD 21001 Thomas Massey (son) 481 Manor Rd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 7/25/12 Aberdeen, MD 4 Donation 5 Other (Specify) Harford Mem. Grds 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Serice Licenses 333 S. Aberdeen, MD Parke St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between nset and Death DOROTHY Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a nonsequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physician the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant 5 Other (specify) Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 2 performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral (Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation after deat Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) òq 4 Homicide determined within 24 hours at To the Funeral D completed filled i Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E Rapp hway, Suite 203 Haure Dobras, Mp 21078 JUL 2 6 2012 State

TOHMH 17 Rev 7/2009

Registrar

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, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	13		ame/Relationship (7 Dumond/I		- 1		_				Proute Number			e, Zip C	ode)	
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				ress of person who	completed cause of	death (Item 23a)	(Type, F	Print)	2020	w	Rodi	d, Har	jes	town,	N	21	740
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2

			For State	State of Maryland /	Department of Health and I Certificate of Death		0010 00717
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Certificate of Death	2. Date of Death	3. Time of Death
	Physicia Medic		Calvin M	liller		July 2	194 th 2012 3:35 AM
J. arrange	Examin		4a. Facility Name (if not institution, give	1 . 1	4b. City, Town, or Location of Death Baltfmore		c. County of Death
	Funeral		5. Social Security Number 6. So	7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	32 Himore City 9. Birthplace (State or Foreign
l.	Director		230-08-3101	EM 2□F 53	Yrs. Months Days Hours Min.	(Month, Pay Year)	5-8 Sountay Sound
-	nd h ow at	<u>۱</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	daryla 8a-f s tified	Director	mo NA	Baltin	nore		1 ✓ Yes 2 ☐ No
	h the l a or 2 be no	a Di	10e. Street and Number		10f. Zip Code		Citizen of What Country?
	ith wit ms 23 must	Funeral	2011 Maizel S	12. Was Decedent Ever in U.S.	21230	US)	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
15-(72 hou r "nat	nplet	15. Decedent's E (Specify only highest gra	de completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business Industry
212	vithin giene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT use retired)	Co	enstruction
	filed y	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maider	n Surname)
Maryland	d Men marke matic	-	David Hate JA.	Delah Calab	Helen I	viller	
Ma	12 shoulth an and and and and and and and and and		19a. Informant's Name/Relationship (T)	mother 2	b. Mailing Address (Street and Number or Rul	fal Route Number, City of	or Town, State, Zip Code)
ore,	of Head fitem		20a. Method of Disposition	20b. Place of	of Disposition (Name of ery, crematory or other place)		Location - City or Town, State
Baltimore,	Page ment tant: I		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Tiomoras nomi otato	Zion Cemetery 7-29	3-121 LOI	nsdowne, MD
Bali	permit Depar Impor any in		21. Signature of Funeral Service Lice				ton Pass Patta mD 21220
			23a. Part 1. Enver the disease, or com shock, o heart failure. List only o Immediate Cause (Final	olications that caused the death. Do ne cause on each line.	not enter the mode of dying, such as cardiac	4	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as consequence	JONEY FAILU	RE	Onset and Death
	Examiner	,		HEPATIC	FALLURE		
ŧ,	D #	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):		
	and and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence	of):		
0	icate be executed physician and s the burial-transit	edical		d			
68760	tificate ng phy as the		IF FEMALE:		-		
Box 6	eath certific attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death			23d. Date of delivery Month Day Year
Ä.	t the dea by the a stached f	hysic	1 Yes 2 No 9 Unknown	9 Unknown	5 U Other (specify)	-	THE TAX TO SEE THE TA
, P.O.	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours a er death. Funeral Director After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions of	entributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death?
Records,	requir been s	Completed by				24a. Was an	24b. Were autopsy findings available
Sec.	Physician: The law this certificate has al director, page 2 3	dwo				autopsy performed?	prior to completion of cause of
ial F	sian: T ertifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Place of Death (Chec		NO TES 2 NO
Ţ	Physic this coral dire	은	1 ☐ Yes 2 No 27. Magner of Death	Hospital: 1 Inpatient 2 ER/O 28a. Date of injury 28b.		ome 5 Residence	
n o	ding th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Time of injury at work? M 28c. Injury at work? 1 \sum Yes 2 \sum No	28d. Describe how inju	iry occurred
Division of Vital	of crattending Page 1 or a set of the set of	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		arm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
Ö	To the Hospital of within 24 hours a To the Funeral D completed filled in	calC	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	death occured at the time, date and place, a	and due to the cause(s) a	and manner as stated
	he Hos in 24 h he Fur pleted	Medical	(Check 2 Medical Exami	ner: On the basis of examination and/	or investigation, in my opinion, death occurred a vledge, death occurred at the time, date and pla	at the time, date and place	e, and due to the cause(s) and manner stated.
	vith To t		29b. Signature and title of certifier	1	29c. License number	29d. D.	ate signed (Month, Day, Year)
)		Illison ?	auard),	VIDI D 5205	/ 0	7/24/2012
			30. Name and address of person who of Allison Regina	. , ,	(Type, Print) allant Fox Lane Bowi	e, MD 21715	5-4003
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 6 2012	32. Registrar's Signature		,	
	31011		JOF 2 0 2212	Jan. 1. 11			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death July 2012 24, 10:11 P M Esther Guier Newman 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7971 Citadel Drive Severn Anne Arundel If Under If Under 24 Hrs. 7. Age (In vrs. last birthday) Social Security Numbe 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Hours Min. 1 🗆 M 2 🗓 F 223-09-1671 96 June 14, 1916 Pennsylvania Usual Residence of Decede 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 💢 No Severn Maryland | Anne Arundel 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 7971 Citadel Drive 21144 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Irwin Lester R. Guier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7971 Citadel Drive Severn, Maryland 21144 Susan LeDoux / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Columbia Gardens Cemetery X Burial 2 Cremation 3 Removal from State ly 31, 2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia . Signature of Funeral Service 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A Will Esone Annapolis Road Odenton, Maryland s that caused the death. Do not enter the mode of , ying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on nterval Betweer Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- Physician/ Medical **Examiner**

Physician/

Medical

10a. State

by Funeral Director

Completed

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Examiner

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Director

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permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu ence.

Baltimore, Maryland 21215-0036

ms 23a or must be

notified

with the Maryland

Medical Certificate: To Be Completed by Physician/Medical Examine the burial-tran attending physician and use as signed by the at Id be detached for should s certificate has b director, page 2 s the funeral director, this s after death. filled in by within 24 hours a To the Funeral D

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

Division of Vital Records, P.O. Box 68766

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome of pregn. 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cont	c BUADO	sulting in the underlyin	g cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
DEGENERATIVE		55158	SPINE	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical	spital:	BER/Outpatient 3 🗆	26. Place of Death (Che	ome 5 Residence	6 Other (Specify)
27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inju	
1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be					

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signatu

Name and address of perso

pleted cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea Month Neissor **Physician** 21:35 eanor 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 84 July 18,1928 Marvland 214-24-0334 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Md. Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 6905 Fenway 21222 Funeral ltems ; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married 0 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natur 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Packer Esskay Meat 11 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Kridenoff Lillian Hammerbacher is marked ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health at Important: If Item 27 is any injury or other trau Marilyn Hammerbacher Sister 6905 Fenway, Dundalk, Md. 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 30 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A. utho 7110 Sollers Point Road, Dundalk, Md. 21222 ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a, Part 1, Enter the disease omplications that caused the death. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final desease as tery **Physician** ronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal dea 2 Fetal death In the past 12 months? Month Day 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 2 No 3 Probably 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No 1 TYes 2 1 No 1 TYes this certificate or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral Certification: 1 Natural 2 Accident After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 4 Homicide after within 24 hours To the Funeral I the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D74308

DHMH 17 Rev 1/2001 11595

State

Registrar

30: Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lina

6 2012

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31. Date filed (Month, Day, Year)

r, den.

32. Registrar's Signature

July 24, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

ox 68760 G Baltimore, Maryland 21215-0036

				Please	Type or Pr						_		_	le.	
■ State					f Maryland / Department of Health and Mental Hygiene 20 2 2375										
			Registrar 1. Decedent's Name	Certificate of Death					Reg. No. 2. Date of Death 3. Time of Death				Time of Death		
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	Examir		4a. Facility Name (if	not institution, give	street and number)	. 00	4	4b. City, Town,	or Location	n of Death		4	c. County of [Death,	
Sunt Joseph Medi 5. Social Security Number 6. Sex 7.											8. Date of Bir	3. Date of Birth 9. Birthplace			
	Funeral Director		215 28 09	24	□ M 2 X F	81	Yrs.	Months Days		Min.	(Month, Da Feb.3,	ay, Year)		Country) larylar	
	nd now	_	Usual Residence of	of Decedent 10b. County		10c. City	. Town or Lo	ocation							side City Limits
	farylar Ba-f sl tified	Director	Maryland	Baltimo	re	Mid	ddle F	River							☐ Yes 2 X ☐ No
	th the N 3a or 2 t be no	al Dii	10e. Street and Num			10f. Zip Code 21220					10g. C	Ditizen of Wha	t Country?		
	ath wi	Funeral	11. Marital Status	nt Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec						American Ind	lian.				
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and	ild be filed Mental Hy iarked oth atic event	To B	17. Father's Name (F			18. Mother's Name Helen				(First, Middle, Maiden Surname) Barr					
aryl	should band Me is mark		19a. Informant's Na		ype, Print)	19b. Mailing Address (Street and Number or Rura									
	nd 2 st ealth a m 27 is		William A	. Wolfe	(Brother)		427	Nollmeye	r Rd.	Balt	imore,	Maı	ryland	21220	
Baltimore,	permit. Page 1 and is Department of Heall Important: If item 2 any injury or other once.				Removal from Stat	e ce	emetery, cre	osition (Name of matory or other pl rematory		-	ate		Location - Cit Ltimore	•	
	permit. P Departme Importar any injur		21. Sign Ture o Fur			Day								-, rui	ylana
8	99 7 8 9		21. Significated Funeral Service sicenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221												
100	hysician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death										val Between		
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 624 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	23b. Was decedent in the past 12 r 1 Yes 2	months? No	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknowr	n 2 □ Feta at time of d	I death 3	☐ Ectopic pregna☐ Other (specify)	ncy				23d. Date o Month	Day	Year
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Vita	ysicia is cert direct	To Be	examiner?	No	Hospital:	26. Place of Death (Check only one) tient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence						idence	ce 6 Other (Specify)		
of	ing Ph		27. Manner of Death	5 Pending	28a. Date of in								injury occurred		
sion	al or Attending F s after death. I Director: After t d in by the funer.	Certificate:	2 Accident 3 Suicide	Investigation 6 Could not be	e	M 1 Tes 2 No					P8f Location	ation (Street and Number or Rural Route Number,			
Division of Vital Records,	cal or A safter al Direct		4 Homicide	determined		Injury - At home, farm, street, factory, office etc. (Specify) 28f. Location (Street, City or Town, S									
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2	Medical Exam	sician: To the best	examination	and/or inves	stigation, in my opi	nion, death	occurred at	the time, date	and plac	ce, and due to	the cause(s)	and manner stated
	To the within To the compl	Σ	only one) 3 29b. Signature and		se Fractaphier. 10	the best of th	- Kilowieuge		se number		Je, and due to		e cause(s) and manner as stated. 19d. Date signed (Month, Day, Year)		
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			For State Registrar	Otato of Marylar		rtificate of E		,	Reg. No. 20	2 2375		
I	Physicia	ın/	Decedent's Name (First, Middle, L.					2. Date of Dea Month July 2	Day Vo	3. Time of Death 14:47 M		
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فمرد		IC1	10115 Prince Pla			Largo			Prince	George's		
	Funeral Director		016 70 7617	Sex 7. Age (In yrs. 1 ★ 1 M 2 □ F 54	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da)	y, Year)	Birthplace (State or Foreign Country) shington, D.C.		
336	yland f show ed at	To Be Completed by Funeral Director	10a. State 10b. County		ity, Town or Lo	ocation	'			10d. Inside City Limits		
	or 28a- notifie		Maryland Prince	George's La	rgo	10f. Zip Code			10g. Citizen of What	1 Yes 2 No		
	with the s 23a c		10115 Prince Pla	ce #203		20774			_	tes of America		
	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at		11. Marital Status 1 M Never Married 2 Married 3 Widowed 4 Divorced	12, Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, 'hite, etc. White		
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Maryland 21215-0036	d be filed w Jental Hygi srked othe rtic event,		17. Father's Name (First, Middle, Last William Edward Ol				18. Mother's Na	ame (First, Middle, COX	Maiden Surname)			
	of Health and Mental F of Health and Mental F f item 27 is marked of r other traumatic ever		19a. Informant's Name/Relationship Debra Baranyi /	Sister	11333	Freas Dr	and Number or R	ural Route Number Potomac	r, City or Town, State, , Maryland	Zip Code) 20878		
Baltımore,	. Page 1 ar iment of H. tant; If iter jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Control	Removal from State	cemetery, crei	osition (Name of matory or other place morial Garde	ens July	Date 31, 2012 I	20c. Location - City Davidsonvi	or Town, State		
Rail	permit. Page Department Important; If any injury or once.		21. Signature of Funeral Syrvice Lice	M0089	6 R ² 6	Name and Address	Pumphrey	Funeral	Home/Rocl	kville, Inc. MD 20850-2805		
	Physician/		23a. Part 1. Enter the disease, or col shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	th. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arr		Approximate Interval Between Onset and Death		
1	Medical Examiner		resulting in death)	a. Pulmor Due to (or as a consec Pulmon	uence of):	- 1	Λ	- 4.				
	incate be executed g physician and as the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for as a sonsec	reches on:	Lasoli		>10715				
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	juence of):								
Ç	ificate be executed g physician and as the burial-transi	ical	risoditing in dodainy East.	■ d	1441130 01/1							
Ö	n cer ificate endi g phy r use as the	an/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		☐ Ectopic pregnanc			23d. Date of	delivery		
BOX.	the ette	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Month	Day Year		
S, P.O	To the Hospital or Attending Physician: The law requires that the death cern within 24 hours after death within 24 hours after death. To the Funeral Director. After this certificate has been signed by the "ttendificompletely filled in by the funeral director, page 2 should be detached or use.	by	Part II. Other significant conditions	contributing to death but not rebrillation	sulting in the u	underlying cause giv	ren in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown		
Division of Vital Records,	he law requ te has beer age 2 shou	Completed	Down's !	Syndrome	-		,	perfor	psy prior death	autopsy findings available to completion of cause of 1? Yes 2 \square No		
	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che		2 No 1	res 2 INO		
	Physic r this c eral dire	2	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe							pecify)		
	anding eath. or: Afte he fund	ficate	1									
	To the Hospital or Attending Physician: "In the Funeral Director: After this certification for the Funeral Director: After this certification for the Funeral director, and the funeral director, and the funeral director, and the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director, and for the funeral director director directors are directors.	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town)						reet and Number or Rural Route Number, a, State)			
	ie Hosp n 24 hou ie Funer oletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	Vithi Vithi Con	2	29b. Signature and title of certifier	1-1		29c. License	number		29d. Date signed (Mo	nth, Day, Year)		
			30. Name and address of person who	complete cause of death (Iter	n 23a) (Type. F	Print) 7 CO	001	eenwas		12012		
			Stuart Tur	Kenitz, M	10	Gree	2n feli	(M)	20770	1.#430		
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature Land	20						

			Please Type or Print amend #5 Per ANA E State of Mary amend#10e Per	in Black I BD G930 8 land Dep ANA BD	ndelible Inl 8/24/2012 Partment of L G931 9/1	c. Ensure A JH Jealth and N 172012 JH	II Copies Iental Hygi	Are Legil	ole.	00750		
			State Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of L	Death	2. Date of Death	g. No.	12	3. Time of Death		
	Physicia			NENS	PRI	UT	Month		30/2	0903 M		
and the same	Medic Examin		4a. Facility Name (if not institution, give street and number)			Location of Death	,	4c. County of				
mary Market	-		Anne Arundel Medical Center 5. Social Security Number 6. Sex 17. Age (In	yrs. last birthday)	Annapo If Under 1 Year	lis If Under 24 Hrs.	8. Date of Birth		Arur 9 Birthpla	nde1		
	Funeral Director		5/8	4 Yrs.	Months Days	Hours Min.	Month, Day,) Dec 7, 1	(ear) .917	Country			
	yland f shoved at	ctor		c. City, Town or Lo					100	d. Inside City Limits		
	r 28a- notifi	Director	MD Anne Arundel	Lothian	1 10f. Zip Code		11	ng. Citizen of Wh	at Countr			
	with the 23a oust be	Funeral	5187 517 Old Solomons Island Rd.		20711		"	USA	at Count	· ·		
	death items		11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	Americar			
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	ted by	1 Never Married 2 Married 1 Yes 2 ANO If Yes, Give Year or Dates.		1 ☐ Yes 2 🗶 No	Specify:			Specify: White			
15-	72 ho n "nat Aedica	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of work (Feb. DO NOT use retired)					16b. Kind of Busi	iness/Indu	stry		
laryland	within giene. ier thar t, the M	To Be Cor	Elementary/Secondary (0-12) College (1-4 or 5+)		educat	ion						
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Nam <i>e (First, Middle, Last)</i> Lloyd Owens		Name (First, Middle, Maiden Surname) ha Elizabeth Clark							
	shoul		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a				te, Zip Co	de)		
e,	and 2 s Health tem 27 other tra		Philip Prout Jr. 20a. Method of Disposition	20b. Place of Dispo				20c. Location - C	ity or Tow	n, State		
mor	Page 1 nent of int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ※ Donation 5 ☐ Other (Specify)	cemetery, cre	ematory or other plac	e)						
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of the control of the	tor 2	22. Name and Addres	ss of Facility St.				1201		
			23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between									
	h, sician/		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions Sequentially list conditions									
Mary .	Medical an and trial-transit	iner	Due to (or as a consequence of): A solver of the solver o							DUE DAS	IÉ YEAL	
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1 2000		,,_	1	100.			
		Examiner	Cause (Disease or injury that initiated events c.	needlience off:								
0	Ψ @ <u>-</u>	_	resulting in death) Last Due to (or as a con									
376(ificate ig phys as the	Physician/Medical	- d									
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 2 by untin 3 by the state death certificate has been signed by the attending physicis for the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Cotopic pregnance Cother (specify)	у			23d. Date of delivery Month Day Year			
P.O.	at the ed by t detach	/ Ph	Part II. Other significant conditions contributing to death but no	ven in Part I.	23e. Did tobacco use contribute to the cause			cause of death?				
S, F	uires t n sign uld be	Completed by	PARKINSON'S DISEASC						Yes 2 No 3 Probably 4 Unknown			
Sorc	law req has bee ge 2 shor						24a. Was an autopsy	/ pri	or to com	y findings available pletion of cause of		
Rec	The la						perform 1 \sum Yes 2	ed? de	ath? Yes 2			
ita	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient		Oth	ace of Death (Checker:						
of Vi	Phys or this eral di	e: To	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
on (ading ath. ir: Afte he fun	ficat	The Natural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No									
Division of Vital Records,	al or Attending Is after death. I Director: After ed in by the fune.	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (Sp.		treet, factory, office	28f. Location (Stre City or Town,	n (Street and Number or Rural Route Number, Town, State)					
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1	ination and/or inve	stigation, in my opinio	on, death occurred at	t the time, date and	I place, and due t	o the caus	e(s) and manner stated.		
	To the within 2 To the comple	2	29b. Signature and title offertifier	1 h	29c. License	214	38	Od. Date signed (Month, Da	19, Year) 2012		
_			30 Name and address of person who completed cause of death	(Item 23a) (Type,	Print DEYEN	SE HWY	, ANN,	APOCI:	Mr	12140)		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's 5	Signature	11							

	101	Maryland / Department of Health	and Mental Hygiene					
	1 - State Registrar	Certificate of Death	Reg. No. 2012 2375					
Physician/ Medical	1. Decedent's Name (First, Middle, Last) Beryl M. Parn	nell	2. Date of Death Month 23 20 Year 5:57 P M					
Examiner	4a. Facility Name (if not institution, give street and number Franklin Square Hoso)		of Death 4c. County of Death Baltimore					
Funeral Director	5. Social Security Number V 6. Sex 1 7. 200 – 28 – 7394 Usual Residence of Decedent	Age (In yrs. last birthday) 75 Yrs. If Under 1 Year If Under 1 Months Days Hours	24 Hrs. 8. Date of Birth Min. Aug. 1977 (1936) 8. Birthplace (State or Foreign Country) PA					
aryland a-f show filed at	10a. State 10b. County MD Baltimore	10c. City, Town or Location Essex	10d. Inside City Limits 1 ☐ Yes 2 🎛 No					
leath with the Maryland tems 23a or 28a-f sho er must be notified at Funeral Director	10e. Street and Number 225 Oberle Avenue	10f. Zip Code 21221	10g. Citizen of What Country?					
o - L.9 -	11. Marital Status 1 Never Married 2 Married 1 Yes 2	ent Ever in U.S. as? 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical	igin? (Specify Yes or No- n, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.					
// 21215-0036 inthin 72 hours after trian "natural", o the Medical Exam Completed by	3 Widowed 4 Divorced If Yes, Give Year or Date 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during mos	16b. Kind of Business/Industry					
d 2121 d 2121 led within 7. Hygiene. other than ent, the Me	College (1-4 or 5+) Elementary/Secondary (0-12) 12th Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Bell Lo							
Maryland 2: 2 should be filed with and Mental Hyging Ith and Mental Hyging Ith and the control of the control o	17. Father's Name (First, Middle, Last) Charles W. Dillow	7 E	er's Name (First, Middle, Maiden Surname) Elfreda Yonkey					
ore, Mai ore, Mai e 1 and 2 sho of Health and If item 27 is r or other traun	19a. Informant's Name/Relationship (Type, Print) Theodore Parnell /s	on 1022 Southern	er or Rural Route Number, City or Town, State, Zip Code) Drive BelAir MD 21014					
Baltimore, M Bartimore, M Department of Health Important: If item 27 any injury or other tr once.	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	Holly Hill Cemeter						
Bal: permit Depar Impor any in	21. Signatur of Furnal Savice Licensee		Funeral Home of Essex 21221					
Physician/	23a. Part 1. Enter the disease, or complications that caushock, or heart fallure. List only one cause on each Immediate Cause (Final disease or condition	used the death. Do not enter the mode of dying, such as fine.	cardiac or respirat ry arrest, Approximate Interval Between Onset and Death					
Medical Examiner	Sequentially list conditions.	as a consequence of):	38. 38. 1					
be executed sician and burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events c	as a consequence of):						
'60 at the burial the burial Edical E	resulting in death) Last Due to (or	as a consequence or.						
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transfed for a second of the funeral director.		rth 2 Fetal death 3 Ectopic pregnancy nt at time of death 5 Other (specify)	23d. Date of delivery Month Day Year					
ds, P.O. uires that the n signed by th uid be detach ed by Phy	Part II. Other significant conditions contributing to dea	th but not resulting in the underlying cause given in Part	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown					
Division of Vital Records, rater death. al Director. After this certificate has been signed in by the funeral director, page 2 should be Certificate. To Be Completed to			24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
tal I	25. Was case referred to medical examine?		ath (Check only one)					
f Vital Physician: this certific ral director, To Be (1 Ves 2 No Hospital: 1 In In 27. Manner of Death 28a. Date of		ursing Home 5 Residence 6 Other (Specify)					
ion of tending Fleath. or: After the funer ificate.	1 Natural 5 Pending (Month,	injury 7 Day, Year) 28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐	28d. Describe how injury occurred					
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After t completely filled in by the funera Medical Certificate:	3 Suicide 6 Could not be	Injury - At home, farm, street, factory, office, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
he Hospita in 24 hours he Funeral ipletely filled	(Check 2 Medical Examiner: On the basis		d place, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s) and manner stated. tte and place, and due to the cause(s) and manner as stated.					
To the within 2 To the comple	29b. Signature and little of certifier	Lw 29c. License number	29d. Date signed (Month, Day, Year) 7 2 4 2012					
10	30 Name and address of person who completed cause Paul A Valle Ming/o	of death (Item 23a) (Type, Print)	ougn m 21286					
State Registrar	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ Mont 4:00 PM ETHEL PRICE Medical 4a. Facility Name (if not institution, give street and number) Laure | Regional Hosp County of Death 4b. City, Town, or Location of Death Examiner Prince HOSPITAL George's aurel -dure 6. Sex Age (In yrs. last birthday) 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Days 1 M 2 X F Months Hours Min 1919 Dec. Director 238-12-8929 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director 1 Yes 2X No MD Prince George's Seat Pleasant 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r Funeral 510 Cedar Leaf Ave. 20743 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 11th Seamstress Georgetown University and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If item 27 is marked any injury or other traumatic Avecage. 2 Lonnie Mason Carrie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Price-Smith/Daughter 6417 Lamont Dr. New Carrollton, MD 20784 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Fort Lincoln Cemetery 7-27-2012 4 Donation 5 Other (Specify) BRentwood, MD 21. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland,MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ESPIRATUR Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE ves, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 12 months? 2 No in the past 12 Day Month Yea Pregnant Unknown 5 Other (specify) Pregnant at time of death signed by the af d be detached fo Yes Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 □ No 3 □ Probably 4 【Unknown 1 Tyes Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 2 Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No ဂ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 8c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F

0

State Registrar

UNEGBU 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifier

32. Registrar's Signature

m

29c. License number

DUSEN

29d. Date signed (Month, Day, Year)

RD SUITE 220 LANGEL, MD 20707.

12

	AME	ND	#25, 27,28A-Fleas	Se Type or Pri ER ME G929 State of M					All Copie Mental H	es Are Le ygiene	egible.	
	Physici Med		1. Decedent's Name (First, Middle, I Bryan LeRoy Pear	rœ,Jr.		Certific	ate of L	Death	2. Date of D Month	Reg. No.	2012	3. Time of Death
	Exami	ner	4a. Facility Name (if not institution, g Upper Chesapeake		enter	4b. C		Location of Dea	th	4c. Cour Har	nty of Death ford C	ounty
	Funera Director		218-68-7711 Usual Residence of Decedent	5. Sex 7. Ag		Yrs. Mont	hs Days	If Under 24 Hrs Hours Min	. (Month, L		Coun	place (State or Foreign try) Limore, MD.
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director		rd County	10c. City, Town	t Hill						0d. Inside City Limits 1 Yes 2 No
	h with the ns 23a or nust be	neral [10e. Street and Number 1 Colgate Drive			10f.	Zip Code	21050		10g. Citizen d Un	of What Cour ited S	states
	036 s after dea al", or itel Examiner	þ	11. Marital Status 1 ▲Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 K If Yes, Give Year or Dates.			cedent of Hi pecify Cuba s 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	14. R B Spec	lace - Americ lack, White, ify: Whi	etc.
	Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			life. DO NOT	work done o use retired)	ation Juring most of wo y Techni		16b. Kind of	Business/In	
	land 2	To Be	17. Father's Name (First, Middle, Las Bryan LeRoy Pear	st)				•		e, Maiden Surna urton		
	, Mary nd 2 should salth and N n 27 is ma er trauma	9	19a. Informant's Name/Relationship Mrs.Marybeth P.			Mailing Addr		and Number or Ri Jarr		er, City or Town		Code) 21084
	Baltimore, Ma permit. Page 1 and 2 st Department of Heath a Important: If item 27 is any injury or other tran once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	ecifu)	∣ Parkw	y, crematory o	or other plac meter	Satu Y July	irday, 07,201	20c. Locatio	ville,	Marvland
	Balt permit Depart Import any inj		21. Signature of Funeral Service Lice	ense Jeffrey L.O	Gair,Sc.Cl c.#M00677	² Ponc 232	and Adams 5 York 1	terraltives Road Tin	Funeral conium,Mar	and Crema cyland 2	ation (1 21093-22	enter,P.A. 215
100	- Ph		23a. Dart 1. Enter the disease, of or shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	omplications that cause y one cause on each lin	d the death. Do no e. -13 D V	ot enter the m	node of dying	g, such as cardia	or respiratory a	arrest,		Approximate Interval Between Onset and Death
14	Examiner		Sequentially list conditions, if any, leading to immediate	b. —	a consequence o					1		
400014	executed an and rrial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o			0	PROVED BY MED	CALEXAMINER		
-		ledica		d	-			CERTIFICATION A	pko			
JR.	Box death o	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3		у			Date of delive	ery Day Year
LOSON	Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the de- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached		Part II. Other significant conditions	contributing to death b		the underlyin	ng cause giv	en in Part I.				e cause of death?
_	f Vital Records, Physician: The law requires this certificate has been sig	Completed by							per	s an 24th	o. Were autop prior to con death? 1 \(\sum \) Yes	osy findings available inpletion of cause of
BRYAN	/ital sician: certific	Be	25. Was case referred to medical examiner?	Hospital:			Otho	ce of Death (Che	ck only one)			
Z.	of V ng Phy ter this ineral d	te: To	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of inju (Month, Da	ent 2 ER/Out		28c. Injury work	4 L Nursing I		how injury occu)
15	ttendir death. death. tor: Af	Certificate:	2 🔼 Accident Investigat 3 🗌 Suicide 6 🗋 Could no	tion JULY 1,	2012 UNK	М	1 🗆 '	Yes 2 No	SUBJEC'			
PEARCE	DIVISION pital or Attendir ours after death. eral Director: Affilled in by the fu		4 Homicide determine	NURS	ury - At home, fari c. (Specify) ING HOME			· · · · ·	FOREST	(Street and Num wn, State)] (HILL,	MD	
K	the Hos nin 24 ht the Fund npletely	Medical	(Check 2 Medical Exa only one) 3 Certifying N	hysician: To the best of nminer: On the basis of e urse Practitioner: To th	xamination and/or	investigation,	in my opinior	n, death occurred	at the time, date	and place, and o	due to the cau	se(s) and manner stated.
A C	To To con		29b. Signature and title of certifier			2	29c. License	number - 3714		29d. Date sign	ed (Month, E	Day, Year)
23,	(1)		30. Name and address of person who	-	eath (Item 23a) (T		とつみで	EARE	NO E	a.mo	102	21014
#	Sta Registr	LC	31. Date filed (Month, Day, Year)		ar's Signature	bar	ern!		17	ELKIK.	NVU	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ PUTMAN BETTY 08.16PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR MOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year 10/3/1932 Country) 423-36-5197 1 - M 2XX **Director** 79 AL Usual Residence of Dec 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director MD Baltimore Randallstown 1 Yes XXNo 5 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 23a **Examiner must** 5412 Old Court Road 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 5 þ 1 Never Married 2 Married 1 Yes : 2XXNo 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White "natural", 3 Widowed 4XX Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : Page 1 and 2 should be file tment of Health and Mental F tant: If item 27 is marked o မှ Hillman Thomas Walker Pauline Sherrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Putman / Son 6423 Grafton Garth Ct. Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 Donation 7/27/2012 Glen Burnie, MD 5 Other (Specify) Atlantic Crematory 21. Signature Funeral Serv 22. Name and Address of FacilitySingleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Procurings Metas tatic Breast Conce disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 140 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director; /
completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0072328 MO 22nd 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar RAGHURAM CHAVA

31. Date filed (Month, Day, Year)

3001 South Manoverstreet/HARBORKOSPITAL BALTIMOREMO

12-05514		Please Type or							010 000
Kevin Parks		State (1-For State Registrar	of Maryland /		ment of Healt icate of Deat	h and Mental F h		Reg No.	012 237
Physician/ Medic Examin	al	Decedent's Name (First, Middle,Last) Kevin	•••		Par	ks	2. Date of De Month July 23, 2	ath Dav Year	3. Time of Death
		4a. Facility Name (if not institution, give Northwest Hospital	street and number)		4b. City, T Randall	own, or Location of Deat		4c County of D	eath
Funeral		Social Security Number 6. S	7. Age	(In yrs. last		r 1 Year If Under 24Hr	's 8 Date of B		Birthplace (State or Foreign
Director		218-92-7996		48	Yrs. Months			17 63	Country) MD
ny	ŀ	Usual Residence of Decedent 10a State 10b. County		10c. City, Tox	an or Location				10d, Inside City Limits
vlary land 28a-f show any <u>d at once.</u>	jo.	MD Baltimo	ore		andallst				1 Yes 2 No
the Mary a or 28a- tified at	Direct	10e. Street and Number 3904 Zurich Roa	a đ		10f Zip	Code 21133		10g. Citizen of What C	
n with rms 23 be no	era	11. Marital Status	12. Was Decedent I Armed Forces?			nt of Hispanic Origin? (S y Cuban, Mexican, Puerl		0- 14. Race - Ar White, et	nerican Indian, Black,
r death	띪	1 Never Married 2 Married	1 Yes 2	X No			to Ricall, etc.)		Black
rs afte ural",	<u>ā</u>	Widowed 4 Divorced 15. Decedent's Education (Specify only)	if Yes, Give Year or Dates: v highest grade com	pleted) 16		No specify: ccupation (Give kind of)	work done	Specify 16b. Kind of Busine	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the Medical Examiner must be notified at once.	pleted	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5		during most of worl	king life. DO NOT use ret echnician		Baltimon	ce Gas &
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c serent, the Medica	Com	17 Father's Name (First, Middle, Last) James Parks				18.Mother's Name	e (First, Middle, I	Maiden Surname)	
2121 ould be f d Mental d Mental s marker itc event,	Lo Be	19a. Informant's Name/Relationship (Typ			19b Mailing Address	(Street and Number or	-	nber City or Town, St	ate, Zip Code)
ealth and 2 sho tent 27 is traumati	-	DeVonne Parks-1 20a. Method of Disposition	Wife		904 Zur		Date	20c. Location - City	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	e crer	natory or other place) Memoria			12 Woodla	
Balti permit. Departm Importa		21. Signature of Funeral Service License	01.1		22. Name and A	ddres of Facility F/H West Vabash Ave	e. Bali	timore, I	Md 21215
Physician	\dashv	23a. Part I. Enter the disease, or complice failure. List only one cause on each		ne death. Do r					Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a E			diovascul	ar Disease			Death
		Sequentially list conditions, b_) T.				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a conse						
executed an and all-transit	Exa	d	ue to (or as a consec		55	25 - 615			
O, s be executed visician and burial - transit	edical	X UNPENDED				01/2012 JH 9-28-12 sm			
cax 68760 eath certificate be attending physicon use as the bu	an/M	IF FEMALE: (3b) Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth		2 Fetal death	3 Ectopic pregn	ancy	23d Date of deliv Month	ery Day Year
Box 68760 The death certificate is the attending physical for use as the bi	Physiclan/Me	1 Yes 2 No 9 Unknown	4 Pregnant at ti 9 Unknown	me or death	5 Other (Speci	fy)			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death all Director: After this certificate has been signed by the finitest director, page 2 should be detached.	<u>a</u>	Part II. Other significant conditions Chronic Alcoholi		but not resulti	ng in the underlying ca	ause given in Part I.		obacco use contribute s 2 No 3 P	to the cause of death? robably 4 X Unknown
ords,	letec						24a. Was		autopsy findings available to completion of cause of
tal Reco	Completed							ormed? death	?
Vital ysiciau: his certi	8	25 Was case referred to medical examiner?	spital 1 Innetice	1 2 TZ ED		Other, The Check			
of Vii ng Physic After this uneral dir	<u>ا</u>	1 X Yes 2 No 27. Manner of Death	28a Date of Injury	y 28t	Outpatient 3 DC D. Time of Injury 28	Bc. Injury at Work?		Residence 6 Ott	ner
Sion C Attending Attending r death r death ector: Af	cation	1 X Natural 5 Pending 2 Accident Investigation				1 Yes 2 No			
DIVIS Pital or A ours after filled in the	Certification:	3 Suicide 6 Could not be determined	(Specify)	ıry - At home,	farm, street, factory.	oifice building, etc.	28f. Location (or Town, S		Rural Route Number, City
O	ल	one) 2 X Medical Examiner:				ne, date and place, and online, death occurred at			
E M H S	Me	29b. Signature and title of certifier	A P			License number	CME	29d Date signed (/	
7	-	Name and address of person who con	npleted cause of dea	プス th/ Item 23a)	(Juni)	O.C.M.E.	· · · · · · · · · · · · · · · · · · ·	July 24, 2012	
4		Theodore M. King, Jr., MD.	Assistant Med		iner 900 W. B	altimore Street, Bal	Itimore, MD 2	21223	
Stat Registra		JUL 2 6 2012	32 Registrarie	Signature	w				

ORIGINAL

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Chao	Proctor

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State of Maryland / Department of Health and Mental Hygiene

			I- For State Critificate of Department of Policy State Registrar			g. No. 201	2 2375
Phys		ın/	Decedent's Name (First, Middle,Last)		Date of Death Month		3. Time of Death
edical Ex	amii	ner	Shea Camya Proctor 4a. Facility Name (if not institution, give street and number) 14b. C	ity, Town, or Location of Death	July 17, 20	12 4c. County of Death	0930 hrs
				/aldorf		Charles	
Fune				Under 1 Year If Under 24Hrs	_	h (MM/DD/YYYY) 9. Biri	
Direc	tor		216-94-5562 1½M 2 F 33 Yrs.	Ionths Days Hours Mir	Apri	Co	Intry) MD
	ì	ŀ	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
i		5	MD Charles Waldorf				1 Yes 2 No
Maryl	be notified at once.	Director		f. Zip Code	10	g. Citizen of What Cour	ntry?
ith the	notific		3558 Seagrape Court	20602		United St	
eath w	ust be	Funeral	1 XNever Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
after d	ner m	by F.	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 No specify:		Specify: Bla	ack
hours	Exam		during most o	sual Occupation (Give kind of f working life. DO NOT use ret		16b. Kind of Business/I	ndustry
36 hin 72 e.	dical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	onstruction		Priva [.]	t o
5-00	the M	히	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M		LE
21215-0036 uld be filed within 7 Mental Hygiene.	event,	Be	William H. Wills Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	Janic	e Proc	tor	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	matic	۱٩		Seagrape Co		ber, City or Town, State	, Zip Code)
l and Health	er trau	ľ	20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee	or nth		Xourial 2 Cremation 3 Removal non-State		7/28/	2 Clinto	on. MD
Balt Sermit.	njury			on Cemetery			
Physic	_	-	23a/Part I. Enter the disease, or complications that caused the death. Do not enter the m	Silver Hil ode of dying, such as cardiac of			MD. 20746 Approximate Interval
/Medi Exami	cal		failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Wound of Head				Between Onset and Death
LAGIIII	161		or condition resulting in death) Due to (or as a consequence of):			-	
	н	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
0.		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	. –			
Soute of	transit	Ĭ.	d				
Division of Vital Records, P.O. Box 68760, other Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	the burial - transit	Medical	UNPENDED	e,g930 8-3-12	sm 		
1876 rtificate	as the	Ž	IF FEMALE: 35. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal december 12 months?	eath 3 Ectopic pregna	ancy	23d. Date of delivery Month	yay Year
Box 687	hed for use as the	Physician/	Pregnant at time of death	(Specify)			
a the de	ached 1		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
of Vital Records, P.O. ng Physician: The law requires that the contract of the	d be detache	ğ D			1 Yes	2 No 3 Prob	ably 4 Unknown
cords law requ	loot	Completed			24a. Was a autops	sy prior to c	topsy findings available ompletion of cause of
Reco	page 2	E C			perform 1 ✓ Yes 2	med? death? 2 No 1 ✔ Ye	s 2 No
ital Rec		8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check			0
of Vi	funeral di	밁	27. Manner of Death 28a Date of Injury 28b Time of Injury		28d. Describe h	Residence 6 Other	Scene
ion tendin	the fu	atio	1 Natural 5 Pending FOUND: FOUND: Accident Investigation Jul 17, 2012 POUND: 0930 hrs	1 Yes 2 ✔ No	Subject shot	self	
Division tal or Attendir rs after death.	filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, far	ctory, office building, etc.	or Town, St	treet and Number or Ru	
Division Hospital or Atten 24 hours after death	ely fille		4 Homicide Capacity Single Parities Total Capacity Single Parities Singl	at the time, date and place, and		e Court , Waldorf , M	
To the Hospital within 24 hours a	completely	Medical	(Check only 1 Certifying Physician: 10 the best of my knowledge, death occurred a one) 2 Wedlcal Examiner: On the basis of examination and/or investigation, and manner stated.				
H 3 F	ک	ĭ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	oth, Day, Year)
			allenge	O.C.M.E.		July 18, 2012	
3			30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Balti	more Street, Baltimore,	, MD 21223		
	_	ate	31. Date from (Month Dal 1994) 32. Registrary Signature	<u>-</u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 23759 State of Maryland / Department of Health and Mental Hygiene John Adams Quigley 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Da July 17, 2012 1020 hrs **Medical Examiner** John Adams Quigley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c County of Death 2921 North Leisure World Boulevard # 306 Silver Spring Montgomery If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ForeignWashington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Months Director Country) DC 215-36-5230 70 1 4M 2 F Sept 3, 1941 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No 28a-f show Silver Spring I, and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Montgomery MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2921 N. Leisure World Blvd #306 20906 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 1X Yes 9 3 Widowed 4 Divorced If Yes, Give Yeer or Dates:

15. Decedent's Education (Specify only highest grade completed) Yes 2 No specify: Specify: white <u>る</u> 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than MD 21215-0036 government 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BB Edward Joseph Quigley Mary Elinor Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10555 Cambridge Ct; Montgomery Village, MD 20886 If item 27 Elinor Walker - sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition fimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State of Department of 4 X Donation 5 Other Specify 21. Sign ture of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Pan J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pur Physician/Medical physician a the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IE EEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year signed by the attending be detached for use as Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 至 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus Completed has been page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' this certificate ✓ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural 1 Yes 2 No 5 death. Pending the Director: 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 6 Could not be or Town, State) determined 29a. Certifier 1 . Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. July 18, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

OCME

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1 - State of Maryland / Department of Health and Merital Hygierie 2 7 7 1 1 1 1 1 1 1 1	23/60
	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth Day Year 1.	Time of Death
344	Medic Examin	al		9.02 M
ر			The Johns Hopkins Hospital Latimore City	
	Funeral Director		TNFANT 1X M 2 F Yrs. Months Days Hours Min. (Month, Day, Year) Country)	(State or Foreign
	nd now at	١	Usual Residence of Decedent 1 50 July 13, 2012 Mary 18	and nside City Limits
	Aarylar 8a-f sh tified a	recto	MD Anne Arundel Annapolis	□ Yes 2 🖔 No
	ith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Married 2 Married 1 No Silver Married 2 Married 1 No White, etc.	
21215-0036	n 72 hours s. an "natura Medical E	Completed	Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	y
21	d within lygiene ther th nt, the	ایدا		
lano	be file lental F rked of ic ever	70 B		3
Baltimore, Maryland	id 2 should salth and M n 27 is ma er traumal		19a. Informant's Name/Relationship (Type, Print) Maria Romero — mother Maria Winters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 544 Coover Rd; Annapolis, MD 21401	
imore	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1	State
Balt	permit. Departimport any inj		21. Signature of Fineral S. vve Licentifice, Director 22. Name and Address of Facility State Anatomy Foard 655 W. Baltimore St; Baltimore, MD 212	201
-× ()	hysician/ Medical	57 A	shock, or heart failure. List only one cause on each line. Innter Ons disease or condition resulting in death) a.	proximate rval Between set and Death
per s	Examiner		Due to (or as a consequence oi).	
	ed sit	mine	Sequentially list conditions, if any reaching to manufact cause. Enter Underlying Cause (Disease or injury	
	cate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	
760	icate be physical sthe b			
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1	Year
ds, P.O.	requires that the by been signed by should be deta	þ	That is, Other significant conditions contributing to death out not resulting in the diddinging dates given in that is	
Records,	The law recate has been page 2 sho	Completed	24a. Was an autopsy fir autopsy performed? 1 ☑ Yes 2 ☐ No 1 ☐ Yes 2 ☐	tion of cause of
ita	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	
Division of Vital	nding Physician: tth. After this certific funeral director,	cate: To	impatient 2 di evocupatient 3 di DOA 4 di Nursing Home 3 di Aesidence 6 di Other (Specify)	
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Certificate:		e Number,
	he Hospit in 24 hour he Funera pletely filk	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To t To t		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	rear)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **TOTAL MAY TO SOUTH TO S	LECT COUR
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 6 2012 A Barrel	111/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 state 18 MERIANA Bep 6222 n7 68462011 and the Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 9:35AM Physician/ 0 a 20/2 Medical 4a. Facility Name (if not institution, give street and numbe 4c. County of Death 4b. City, Town, or Location of Death Examiner izabeth altimor ent 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth Funeral Month, Day Year) 19<u>36</u> Months Maryland 219-32-4828 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f shov must be notified at 10b. County 10a. State 72 hours after death with the Maryland Director 1 🗆 Yes 2 💆 No Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 21044 10e Street and Number 5138 Durham West Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or iten edical Examiner r Armed Forces? Black White etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 🗌 Yes 2 🔀 No Completed 3 Widowed 4 X Divorced Year or Dates **1955–58** the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Retail furniture salesman Be 18. Mother's Name (First, Middle, Maiden Surname) unk filed 17. Father's Name (First, Middle, Last) unk permit. Page 1 and 2 should be flie Department of Health and Mental I-Important: If Item 27 is marked or any injury or other traumatic ever James H. Rew <u>Catherine Lucinda Mae Byrne</u> Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5138 Durham West; Columbia, MD 21044 19a. Informant's Name/Relationship (Type, Print) Michael Cesario - friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Funer ervice Licensee Ronald S. Jade, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cins m Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and I-transit Exami executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural Accident 5 🗌 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Mo

30. Name and address of person who complete

h, Day, Year)

NW

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cause of death (Item 23a) (Type Print)

22. Registrar's Signature

0

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Raymond Reeley Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 0 sedale Franklin Savare 8. Date of Birth (Month, Day, Year) May 25, 1919 If Under 24 Hrs. Hours Min. last birthday) If Under 1 Year **Funeral** 215-07-8973 93 Director 1 **X** M 2 □ F Usual Residence of Dece 28a-f show 10a. State 10c. City, Town or Location the Maryland by Funeral Director notified Md. Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 'n must be 23a 9830 Sadler Lane 21128 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ecley, Raymond 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Wildowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Engineer 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked o any injury or other traumatic ever မ John Reeley Bessie Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vonnie Eady Daughter 9830 Sadler Lane, Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Sonal re of Eup Mal Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, a shock, or heart failure. List Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an cate has by page 2 s performed certificate 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director: filled in by the 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifie 29c. License number 007314 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAN

4:07P 2012 4c. County of Death Himore 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2X No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry US Government 20c. Location - City or Town, State Baltimore, Maryland Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 1,4000 Franklin Square Drive Baltimore moza37

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

32.

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death MONO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreig)
 Country) **Funeral** Director 1 M 2 X F 1928 Md 10/13 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Md Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? arkside 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black White etc Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 MNo Specify. Specify: African American 3 ₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Domestic HouseKeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WILSON ELLA Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart (Daughter Balto, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cometery, crematory or other place, arkwood Cemetery Baltimore, Md GREENE FUNERAL SOYS PA 22. Name and Address of Facility Vaughn 21. Signatur Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Examiner 4 weeks Securitizity list condition if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown lo d Dav Year signed by the at d be detached for Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform Director: After this certificate Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practitions of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practitions. To the basis of my moved day obetter presented at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practitions. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 3a) (Type, Print)

State Registrar 32. Registrar's Signat

2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:15 PM <u>William</u> James Randall July 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1808 Hillenwood Road Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Unknown Months Days Hours (Month, Day, Year) **Director** 372-34-8716 1 X M 2 🗆 F Yrs 82 12/31/1929 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be Funeral 1808 Hillenwood Road 21239 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian er than "natural", or iter the Medical Examiner Armed Force: Black. White, etc. þ 1 Never Married 2 X Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Beauty Supplies Salesman Be Unknown 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florine Randall / Spouse 1808 Hillenwood Road, Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 07/25/2012 Hanover, Maryland Signature of Funera 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CalareMaln \$ hod 10 Re disease or condition Medical resulting in death) as a consequence of) Examiner nen Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of) burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death Unknown signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostate Lancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work s after death. 1 Yes 2 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Costifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9b. Signature 4 Hending MD 2012

Registrar

State

3512

21218

who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Richardson 7:20 P M July 2012 Shirley 18 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Elkridge 6025 Bauman Drive Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F **Director** 216-40-1585 10-06-1920 MD Usual Residence of Decede 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f sho notified at Funeral Director Elkridge 1 Tes 2 X No MD Howard the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö pe r items 23a iner must be United States 21075 6025 Bauman Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten ledical Examiner r 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Black Completed 3XXWidowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 8 other 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental Hitem 27 is marked o' other traumatic eve 2 Oliver Smith Lillian Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6025 Bauman Drive, Elkridge, Maryland 21075 Anita L. Richardson - daughter Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XX urial 2 Cremation 3 Removal from State Arbutus Mem. Park 07-24-2012 Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at of Funeral Service Licer 21. Signature, MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILATERAL Physician/ MONTHS Medical resulting in death) Due to (or as a consequence of) **Examiner** MITRAL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of AKS ORONARY burial-tran that initiated events the Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Division of Vital Records, P.O. Box 68760 \ll P ADRT, C VALUE REPLACEMENT Completed by Physician/Medical STENOS HORTIC the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death igned by the a be detached f 1 ☐ Yes 2 ≥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS DIABETES 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of PERTENSION 24a. Was an autopsy performed Yes 2 death? 25. Was case referred to medical Be (26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: Other:
4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in b Medical 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Luni, Mis 12012 **ZZ83Z**

State

Registrar
DHMH 17 Rev 06-2011

, MD 5808 Main Street, Elkridge, Maryland, 21075

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kim

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 23, 9:50 A Physician/ 2012 Harris E. Reavin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 4315 Ivy Glen Road If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 089-40-2118 Hours 1 M 2 □ F Director New York March 30, 1945 67 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 X No Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ntal Hygiene. ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral United States of America 20906 4315 Ivy Glen Road 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene, item 27 is marked other than "natural" or item Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify: If Yes, Give Specify. White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Contracting Computer Professional Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sara Katz Benjamin Reavin or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4315 Ivy Glen Road, Silver Spring, Maryland 20906 Susan M. Lender / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) July 25, 2012 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State Montgomery Crematorium Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser k²² Name and Addres of Facility Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause If incl Physician/ Ischemic Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy director, page 2 performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 🔀 No Hospital ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 🛚 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Number Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) July 24, 2012 D35370 no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 17125 Rockville Pike #104, Rockville, Maryland 20852 Jan Bachowski, M.D.,

ORIGINAL

32. Registrar's Signature

31. Date filed (Month, Day, Year)

26 2012

State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Shante Y Reedy 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 19, 2012 0335 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death NI **Baltimore** Sinai Hospital If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Days Director Country) 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Iny 10b, County 1 Yes 2 No 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 sho Director 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Yes Yes 2 No specify: If Yes, Give Yaar 4 Divorced ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 OME MA 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) JOANN 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. nformant's Name/Relationship (Type, Pri If item 27 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Domation 5 Other Specify 21. Signature of Funer I Servi Approximate Interval Birler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical signed by the attending physician I be detached for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 至 1 Yes 2 No 3 Probably 4 V Unknown Obesity Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) B examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 V Natural 1 Yes 2 No neral Director: filled in by the f Pending 24 hours after death. Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie July 19, 2012 O.C.M.E. K1 Masse 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year)

JUL 2 6 2012 Registrar's Signal State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 2345 **Physician** John Raymond /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore of Maryland Medical Center n/a University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20,1924 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 217-26-9381 88 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ire Medical Evartimer, wat be redified at 10a. State 1 □Yes 2√2 No Director Baltimore Maryland Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 615 Chestnut Avenue #1115 21204 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 2□No 1943-1 XXYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced 1946 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales 1 and 2 should be filed wi Health and Mental Hygier tem 27 is marked other th Auto 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Raymond Smith Frances Ruth Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 615 Chestnut Avenue #1115 Towson, Maryland 21204 Jean Hall Smith / wife other t permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, Maryland Metro Crematory, Inc. 107/26/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 🖣 299 Frederick Road Baltimore,Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Intrapurenchymal nemorrhage disease or condition resulting in death) /Medical Due to (or a a consequence of). Examiner erebrovascular Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending plant for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes disease page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The lwithin 24 hours after death.

To the Funeral Director: After this certificate ha 1 ☐Yes 2 ZNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 251 4878 12541 30. Name at address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sabolick DO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Backs

32 Registrar's Signature

R. Adams Cowley Shork Trauma Center 22 S. Greene St. Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day Physician/ 2012 Theresa Spath 24 4:55 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care Rossville Baltimore Rosedale Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Pennsylvania 216-32-0461 95 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Baltimore Rosedale 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 1201 Krueger Avenue United States nit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mantal Hygiene. ovtratt. I fitem 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hairstylist Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhelm Krahling Margaret Von Drunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Edwards / Daughter 1201 Krueger Avenue, Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2X Cremation 3 Removal from State Metro Crematory Inc. 07/25/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland In 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Core Assouthed forumoni Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 4 hours after death.
Panneral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Yes been signed by the a should be detached t ☐ Yes ∠ . ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1XX Natural 5 Pending Investigation Accident completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

Name and address of

sweeta

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

VONE

Nag

2 6 2012

D0073005

29d. Date signed (Month, Day, Year)

Am Noods Rd Baltimore MD 2123

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

file 2 Month 2 Day 2 ear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Scott Physician/ Month 2012 Year)aisy 22:45 PM TUL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Care Center Baltimore N/A Social Security Number . Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 XF Months Days Hours Min. 212-24-7880 Month Day, Year 6/1926 MD **Director** 86 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou amportant: If item 27 is marked other than "natural", or items 23a or 28a-f shou ampiriup or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5822 Moore's Run Ct. 21206 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) N A College (1-4 or 5+) Brager Gutman Warehouse Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Burrell မ Thelma Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaShore J. Scott-Daughter 5822 Moore's Run Ct. Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Garden of Faith 7/26/2012 Baltimore, MD March F/H- East 21. Signature of Fu-22. Name and Address of Facility 1101 E. North Ave. Baltimore, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final arrhythmia Physician/ disease or condition) Medical resulting in death) heart failure Examiner Pars Sequentially list conditions cause. Enter Underlying Exami the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last pertension attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Year Day Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diaber Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? uremia 24a. Was an cate has page 2 s autopsy performe After this certificate funeral director, pag Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X**No ည 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 18, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

125

nought

32. Registrar's Signature

Core

31. Date filed (Month, Day, Year)
JUL 2 6 2012

> 5505 Hopkins Bayview Circle, Baltimore Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of N	/larylan				and M	ental Hy	giene	201	2	00770
			State Registrar			Cen	ificate of	Death			Reg. No	201	4	23772
	Physicia Medic		Decedent's Name (First, Middle, I	illian Tw	iet Sh	evitz	_			2. Date of Dea Month July		^y 2012 ^{Yea}	ar	3. Time of Death 11:43 pm
	Examin	er	4a. Facility Name (if not institution, g			600	4b. City, Town,				4c.	County of D		1 5 m 2 fr 4
	Funeral		3200 N. Leisure 5. Social Security Number 6		ige (In yrs. la		If Under 1 Year	ver Sp		8. Date of Birt	h			ce (State or Foreign
	Director		579-05-0962	1 □ M 2 🂢 F	93	Yrs.	Months Days	Hours	Min.	(Month, Day	v, Year)		Country)
3	or at	ايا	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	ation			April (71,1	919		York d. Inside City Limits
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	or 28	늅	10e. Street and Number	9			10f. Zip Code		-	1	10g. Cit	izen of What	Countr	
:1	s 23a nust b	Funeral Director	3200 N. Leisure	world Bli	od., #	809		2090	16			u.	.s.A	١.
1	r item iner n		11. Marital Status	12. Was Decedent Armed Forces 1 \(\text{Yes} \) 2	t Ever in U.S	. 13. W	as Decedent of Yes, specify Cub	Hispanic Orig an, Mexicar	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		14. Race - A Black, W		
336	al", o	d b	1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced	d 1 ∐ Yes 2) If Yes, Give Year or Dates.	(J No	1	□ Yes 2 X]N	o Specify:				Specify:		Ihite
2-0	nour	Completed by	15. Decedent's (Specify only highest	Education			nt's Usual Occu		4 - 5 1 - 1		16b. Ki	ind of Busine		
121	nin 72 ne. than ' ie Mei	E I	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	nd of work done NOT use retired	1)		·		nı	, D1	. ' .
g 25	Hygie Hygie other ent, th	امها	17. Father's Name (First, Middle, Las	<u>Z</u>		Admin	istrativ	1		(First, Middle, i	Maide - 1	B'na	L B'	rith
<u>lan</u>	outo be lined within 7.2 frouts after dearth with the Maryland of the Marlat Hygiethe. marked other than "natural", or items 23a or 28a-f show marke other, the Medical Examiner must be notified at	힏		unuel Tures	tsky			10. IVIOLIR	,	Evelyn			enac	che
ary	and M is mai		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Street	t and Numbe	er or Rural I	Route Number	; City or	Town, State,	Zip Co	de)
Z	ealth m 27		Susan Hutt -	Daughter				len Co	wrt,	Gaithe	rsbu	urg, Ma	aryl	20878 20878
lore	perim. Tager and 2 should be fined within 7z hours after death with the Marykand Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐ Removal from Stat	ce ce	emetery, crema	tion (Name of atory or other pla	ace)		ate		ocation - City		•
Itim	artmer ortant injury		4 ☐ Donation 5 ☐ Other (Special Service Lice)		Mt.		on Ceme							
Ba	lmp any once		Kataina Service Lich	Consith	Mas									Iome, Inc. MD 20904
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	omplications that cause	ed the death							<i>ye</i> 6,00	1	pproximate
Pł	ysician/		Immediate Cause (Final disease or condition		rythmi	.a.								nterval Between Onset and Death
	Medical xaminer		resulting in death)	a	s a conseque									
		er	Sequentially list conditions,	b.	E E E O IE BOOK	and and								
bet	ansit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			since our								
execu	an and rial-tra	Ĭ.	resulting in death) Last	C. Due to (or as	s a conseque	ence of):								
68760 certificate be executed	ohysician and the burial-transit	dica	•	d									_	
Box 687	been signed by the attending pl should be detached for use as t		F FEMALE:	23c. If yes, outcom	e of pregnan	ICV						-	_	
OX eath o	atten I for u	iciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live Birth 4 ☐ Pregnant	2 🔲 Fetal	death 3	Ectopic pregnar Other (specify)	псу			1	23d. Date of Month	,	ay Year
	by the	hysi	1 Yes 2 No 9 Unknown	9 Unknown				_						
P.O.	gned b	ğ	Part II. Other significant conditions					iven in Part I	l.	23e. Did to	bacco u	se contribute	to the	cause of death?
rds,	een si	ed	Hypertension,		rtery	viseas	e,			1 🗆 Y	es 2 [X No 3 □	Probal	oly 4 🗌 Unknown
CO	has b	Completed	Renal Insuffic	ciency						24a. Was a	sy		o com	/ findings available letion of cause of
—	ficate or, pag		25. Was case referred to medical				20.5			perfor 1 Yes			Yes 2	□ No
Vita	s cert direct	To Be	examiner? 1 Yes 2 X No	Hospital:	tient 2 \square F	R/Outpatient	LOH	Place of Deat		e 5 X Reside	ango 6	Othor /Sp	ooiful	
of Physical	ter thi		27. Manner of Death 1 X Natural 5 Pending	28a. Date of in	ury 2	28b. Time of injury	28c. Inju	ry at		d. Describe ho			еспу)	
ion	leath. tor: Ai the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	ion			M 1 🗆	Yes 2	No					
Division of Vital Records, P.O.	within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be		4 Homicide determine	28e. Place of Ir	ijury - At hon tc. <i>(Specify)</i>	ne, farm, stree	t, factory, office		28	3f. Location (St City or Town		Number or F	Rural Ro	oute Number,
Spits	hours uneral	Medical	29a. Certifier 1 X Certifying Pl	nysician: To the best of	of my knowle	edge, death oc	curred at the tim	ne, date and	place, and	due to the cau	use(s) an	d manner as	stated.	
the H	hin 24 the F mplete		only one) 3 L Certifying N	miner: On the basis of urse Practitioner: To t	he best of m	knowledge, o	eath occurred at	the time, dat	te and place	e, and due to th	ne cause(s) and manne	r as sta	ed.
٥	. 6 ⊗	ľ	29b. Signature and title of certifier	2000	00 V	y	29c. Licens	D425	1 8	2	29d. Date	e signed (Mo		
			30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Type Pri	nt)	0-125				July	1 26	, 2012
12			Gul Chablani, M.					rive,	#310,	, Germa	intov	vn, Ma	ryla	and 20874
	Stat	٠ ا	1. Date filed (Month, Pay, Year)	2012 32. Signatur	rar's Signatu	1								
) / 50000	Registra		JUL 26	UIZ Buse	u p	. Asa	Ke							
DHMH	17 Rev 06-2	011												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lucia Santucci 1320 М 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 9. Birthplace (State or Foreign Country) T + n P 11 If Under 1 Year If Under 24 Hrs. 8 Date of Birth Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Months Days Min 99 M27/12/19/12 Italy Yrs. Director 214-80-6116 Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 28a-f 1 Yes 2 X No Silver Spring Maryland Montgomery ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20906 U.S.A. 2101 Briggs Road death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ò 1 ☐ Yes 2 🂢 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify "natural" Completed 3 XWidowed 4 ☐ Divorced Specify Caucasian the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 7 is marked of မ Maria (Unobtainable) Alberto Sanguine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health 3404 Randolph Road, Silver Spring, Maryland 20902 Sergio Santucci - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 2 Cremation Removal from State Department of Important: If any injury or once. Gate of Heaven Cem. 07/21/2012 Silver Spring, Maryland ion 5 🗆 Other 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature Funeral Ser 10070 11800 New Hampshire Ave., Silver Spring, MD 20904 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the of shock, or heart fail Approximate Interval Between Onset and Death re. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) **Examiner** Peroxysmal Atrial Fibrillation with pauses leading to CA Secuentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Persistant Leukocytosis that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 **Y** No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No ည 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

6 2012

1500

Registrar's Signat

Anisha Kumar,

D0073240

Forest Glen Road, Silver Spring, Maryland 20910

29d. Date signed (Month, Day, Year)

July 17. 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mary Lee Smart 1945 2012 . Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center Olneu Montgomeru Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days **Director** 223-36-5525 1 - M 2 X F 83 02/22/1929 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 X No Maruland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 1224 Millgrove Road 20905 u.s.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Yes 2 X No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Edmund Kester Bertha Sarley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 Millgrove Road, Silver Spring, Maryland 20905 John Owen Smart - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 07/30/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 2,11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PULMONARY Physician/ MASSIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 L Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) D26571

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of

10605 CONCORDST KENSINGTON, MD 20895

ed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 EILEEN CECELIA SCOTT 1:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days July 2, 1 M 2 X F Months Hours Min Year) 1952 Director 60 061-44-4036 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zin Code ō 10g. Citizen of What Country? Funeral 23a 339 Scott Drive USA items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Financial Services Financial Analyst Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c 2 Arthur Scott Eileen Riegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Drive, Silver Spring, MD 20904 Clifford Laufer / husband other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, ö injury 7/22/2012 West Arundel Crem. Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Ave, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between newous 3 months Immediate Cause (Final Retractory I system Physician/ Medical resulting in death) Due to (or all consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir burial-transi that initiated events Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month Day Year Pregnant at time of death ned by the a e detached for 4 ☐ Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has perform certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? completed filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital 1 Tes မ √☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical

State

Registrar

To the within 2

29a. Certifier

(Check

only one)

31. Date filed (Month

29b. Signature and title of certifie

NISHANT TAGEJA

Day Year

Physician (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signafure

DHMH 17 Rev 7/2009

11/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4301092385

10 CENTER DRIVE, BETHESDA,

29d. Date signed (Month, Day, Year)

20/2

MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 830A M HeN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** NWall 7. Age (In yrs. last birthday) 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number **Funeral** Months 1 M 2 F Min. Country) Yrs **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 Ges 2 No 28a-f 10e. Street and Number 10g. Citizen of What Country? ò must be 23a 1979 21222 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me once, Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be 1 nent of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONENEI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bradley-Askton 22. Name and Address of Facility PA, 2134 Willow SYING 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Stroke disease or condition resulting in death) da Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Directo for as a por section neightran and Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? To the Hospital or Attending Physician; The law requires that the death Month Day Year detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Multi-infarct Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 28d. Describe how injury occurred 1 Natural 5 \square Pending within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 2 No Accident Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 301 Building Suite 1100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

Colleen Christmas

Date filed (Month, Day,

view Medical Center

Baltimore, Mary land

Johns Hopkins Bry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	te of Maryland / Dep			Hygiene	0010	00777	
			1 - State Registrar	Ce	ertificate of Deat		Reg. No.	2012	23/1/	
	Physicia		1. Decedent's Name (First, Middle, Last) Ruth O.	Shaw		2. Date of July		2 0 ar2	3. Time of Death 7:51 P M	
1	Medic Examin		4a. Facility Name (if not institution, give street an	d number)	4b. City, Town, or Locat			4c. County of Death		
1			1112 Maple Avenue		Rockville	9	Mor	ntgomer	у	
	Funeral		5. Social Security Number 6. Sex 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	7. Age (In yrs. last birthday,	If Under 1 Year If Under 1	nder 24 Hrs. 8. Date of urs Min. (Montal	of Birth h, Day, Year)	9. Birth	place (State or Foreign ntry)	
	Director		Usual Residence of Decedent	X F 87 Yrs.		Apri	19, 192	25 Mary	yland	
	and show	<u></u>	10a. State 10b. County	10c. City, Town or L	ocation			1	10d. Inside City Limits	
	Mary 28a-f otifie	Director	Maryland Montgomery	Rockv	ille				1 🌠 Yes 2 □ No	
	h the	a D	10e. Street and Number		10f. Zip Code			en of What Cour		
	ms 2.	Funeral	1112 Maple Avenue	Decedent Ever in U.S. 13	20851	- Original (Conseils Vos or		ed Stat		
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 If Ye	Specedent Serving 1.5.	. Was Decedent of Hispanic If Yes, specify Cuban, Mes 1 Yes 2 No Spe			4. Race - Americ Black, White, pecify: White	etc.	
9-0	hours natur lical I	Completed	15. Decedent's Education	16a. Dec	edent's Usual Occupation			d of Business/In	dustry	
218	iin 72 ie. han " e Mec	dmo		ege (1-4 or 5+)	e kind of work done during in DO NOT use retired)	most of working		gomery (
121	d with lygier ther t	Be C		12 Cafe	teria Staff			ic Scho	ols	
Maryland 21215-0036	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I traumatic event, the Mec	To B	17. Father's Name (First, Middle, Last) Charles Russell O'Ro	urke		Mother's Name <i>(First, Mi</i> oldie Hiles		mame)		
ary	nd Me		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Nu			own, State, Zip (Code)	
	id 2 sh salth a n 27 is er tra		Karen S. Lumpkin / Da		Auburn Avenu					
altimore,	Page 1 and nent of Heal ant: If item 3 iry or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre Norbeck Me	position (Name of ematory or other place) morial Park	July 28	.	ation - City or To		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Sorgice Licensee	M01305 3	22, Name and Address of F. obert A. Pumphro 00 West Montgome		me/Rockvi ockville,	lle, Inc. Maryland	° 20850–2805	
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not er					Approximate Interval Between	
o kij	hysician/		Immediate Cause (Final disease or condition	Congestive He	art Failure			- 4	Onset and Death	
	Medical Examiner		resulting in death)	ue to (or as a consequence of):	_					
		ē	Sequentially list conditions, b.	Coronary Arte	ry Disease				9 Years	
	ed	Examiner	cause. Enter Underlying Cause (Disease or injury	Hyperlipoprot	einemia			1	.0 Years	
	be executed sician and burial-transit		that initiated events c. ——	ue to (or as a consequence of):						
90	te be exe tysician the burial	dical	d							
876	tificat ng ph s as th	Mec	IF FEMALE:							
Box 687	Attending Physician: The law requires that the death certificate be executed redeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	es, outcome of pregnancy Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23	Bd. Date of delive Month	ery Day Year	
P.O.	hat the		Part II. Other significant conditions contributin	g to death but not resulting in the	underlying cause given in F	Part I. 23e.	Did tobacco use	contribute to the	ne cause of death?	
S,	uires t n sign uld be	ed by	Hypertension				1 □ Yes 2 🛣	No 3 Pro	bably 4 🗆 Unknown	
of Vital Records,	w req ts bee 2 sho	Completed						24b. Were auto	psy findings available mpletion of cause of	
Rec	The law ate has I page 2 s	Com				1 🗆	autopsy performed? Yes 2 X No	death?		
[a]	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?			Death (Check only one)				
Z.	hysic this co	၉	1 ☐ Yes 2 ☒ No Hospital:	1 Inpatient 2 ER/Outpatient		Nursing Home 5 K)	
n of	ding F h. After t funer	Certificate:	1 X Natural 5 ☐ Pending	Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work? M 1 1 Yes	_	ribe how injury o	ccurred		
Siol	Attend deatl ctor: by the	ijį	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home, farm, s			ion (Street and N	Number or Rum	Route Number	
Division	al or A s after I Dire ed in b			building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		r Town, State)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	29a. Certifier 1 Certifying Physician: 7o (Check 2 Medical Examiner: Oh ti	the best of my knowledge, death he basis of examination and/or inve	occurred at the time, date	and place, and due to t	he cause(s) and late and place, ar	manner as state	ed. use(s) and manner stated.	
	thin 2 the f	Me		troner: To the best of my knowledg		e, date and place, and du	e to the cause(s)	and manner as	stated.	
	≒ ≥ ₽ 8			/	D16495			signed (Month, 1		
Ų			30. Name and address of person who completes	d cause of death (Item 23a) (Type.			July			
5			Joel Goozh, M.D. 104	401 Old Georget	own Road, #10	04, Bethesd	a, Mary	land 20	814	
	Stal Registra			32. Registrar's Signature						

DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 122 Cedar Hill Road Brooklyn Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Director 214-52-6433 63 1 M 2 F Yrs 09/10/1948 Maryland Usual Residence of Decedent fshow 10c. City, Town or Location 10d. Inside City Limits or then "natural", or items 23a or 28a-f sho 10a. State filed within 72 hours efter death with the Maryland Completed by Funeral Director 1 Yes 2 XNo Anne Arundel Brooklyn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 U.S.A. 122 Cedar Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2X No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Movie Theater Manager Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mentel H f item 27 is marked of r other treumatic ever permit. Page 1 end 2 should be file Department of Health and Mentel I Importent: If item 27 is marked of any njury or other treumatic eve once. ည Ruth Abbott Cowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Cedar Hill Road Brooklyn, MD Mr. Kenneth Smith / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 07/26/2012 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licens Glen Burnie, MD MO1479 Ded Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused they eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physician end for use as the burial-transit or Attending Physicien: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Yes 2 No After this certificete has been signed by the funeral director, page 2 should be detached g Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MSTATIC UNG Division of Vital Records, 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending s after death. 1 Yes 2 No the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 2012

State
Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cau

of death (Item 23a) (Type, Print)

32. Rajistrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2012 9:20 A M Jean Schlosburg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 212-60-6222 1 □ M 2 🖾 F Nov 30, 1951 Maryland 60 Usual Residence of Decede ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10h Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Germantown MD Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral United States 19713 Webster Court 20874 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ School Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annette Anita Cohen Joseph Siamon Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germantown, MD 20874 Alan Schlosburg / Husband 19713 Webster Ct. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/27/2012 Woodbine, Maryland Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or irijury The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68766 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has tuneral director, page 2 s autopsy performed? Yes 2 🖾 N 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 🔀 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d, Date signed (Month, Day, Year) 7.24.12 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

Registrar

Debrah Miller

31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

Rockville, MD 20855

6001 Muncaster Mill

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ July 25, Melvin Franklin Traband, Sr. 6:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Lutherville Examiner 4c. County of Death Baltimore Stella Maris Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days Hours 214-20-2831 **Director** 1 XM 2 □ F 84 10/11/1927 Maryland 28a-f show permit. Paga 1 and 2 should ba filad within 72 hours after death with the Maryland Dapartment of Health and Mantal Hygiane. Important: If item 27 is marked other than "hatural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at agree. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 3713 Lambson Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes : 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Gas Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Traband, Sr. Mary Agnes Emge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Mildred Traband (Wife) 3713 Lambson Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Mem. Gard: 07/28/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme in e Cause (Final disease or condition Physician/ SMGE ulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transit Exam Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be exacuted Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 signed by the attanding phys d ba detached for use as tha IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day 5 Other (specify) Year MELVIN TRABAND ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by aftar death. I Director: After this certificata has bean sig d in by the funeral director, paga 2 should b 2 1 1 Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 ☐ Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No |요 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 20 2013 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore Roseda Franklin Square Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 □ 18-28-25 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ust be notified at 1 ☐ Yes 2 ☑ No Funeral Director Daltimore 10g. Citizen of What Country? 10e. Street and Number ö 21206 23a 606 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Important: If Item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Eventure 1: Black, White, etc. 2 10 Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) D21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Facility 21. Signature of Funeral Service Ligensee 22. Name and Address of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, Immediate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** leural disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due t (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Day Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Toknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 No 1 □Yes this certifical 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Ko Harti 1 is V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kottarathil 9000 Franklin square Drive Baltimore, MD 2123/

State Registrar Date filed (Month, Day, Year)

oistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ITUS omas 6:00 AM 2012 Ü Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Residences House CTREEN altimor 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours 1 X M 2 - F Months Days 11/17/1935 Country) 76 Director 217-30-5197 MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 3300 Benson Avenue Apt. 326 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black White etc. ģ 1 Never Married 2 Married 1 X Yes 2 No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Sidney Titus, Sr. Florence Virginia Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7918 Colchester Court Mr. John Locantore / Friend Pasadena, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/27/2012 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licen Glen Burnie, MD MO1479 Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ ronary disease or condition Medical resulting in death) Due to or as a consequence of Examiner abet Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical PMIC Box 68760 for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death ed by the a 2 🗌 No a Unknown a 🗌 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been Hyputhyweidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26 Place of Death (Check only one) Hospital 2 X No Other: 1 Tes ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WM 3320 Benson venue

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Marylar	nd / Depa	artment of	Health an	nd Menta	l Hygier	ne			
			State Registrar		Cer	tificate of	Death		Reg.	No. 20	12	2378	-
i i			1. Decedent's Name (First, Middle, Last,)					of Death	V	1 1	3. Time of Death	1
	Physicia Medio		Sandra Jo Tur	ner				Jul		Day Yea 22, 20]	2	6:50 P ^M	
	Examin	-	4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town,	or Location of D	Death		4c. County of D	eath		٦
أتميد			903 Autumn View C	ourt		Bel Ai	r			Harfor	d		
	Funeral		Social Security Number 6. Sex		last birthday)	If Under 1 Yea Months Days			of Birth	9.	Birthpla Countr	ace (State or Foreign	٦
	Director		233-76-9421] м 2 Х F	Yrs.	Worth's Days	I Hours						
	t ow		Usual Residence of Decedent 10a. State 10b. County	100 0	65 ty, Town or Loc	l ation	1 1	09/	21/194	10 WE		Virginia d. Inside City Limits	\dashv
	yland f sh ed a	cto	,			allon					110	1 ☐ Yes 2 X No	
	28a notifi	Director	MD Harford	Be	l Air	1401 7: 0 1			1				4
	th the	al [10e. Street and Number			10f. Zip Code				Citizen of What	Counti	y?	
	th with ms 2 must	Funeral	903 Autumn View C		0 140 1	2101		0 (C=0 sife; Van		J.S.A.			\dashv
	r dea		11. Marital Status 1 ☐ Never Married 2 X Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No	5. 15. V	Vas Decedent of Yes, specify Cu	ban, Mexican, P	uerto Rican, e	c.)	14. Race - A Black, W			
99	within 72 hours after death with the Maryland gienie et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 N	lo Specify:			Specify:	Whi	te	
ŏ	hours ratur ical	Completed	15. Decedent's Ed	ucation		ent's Usual Occi			16b	. Kind of Busine			1
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7	withi giene er th , the		Ziomonary Cooonaary (o 12)	2	Reg	istered	Nurse			Health	care	<u> </u>	4
b	filed al Hy d oth vent	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, A	Aiddle, Maide	en Surname)			
<u>Ja</u>	d be Menta arked atic e	욘	Sameul Mazzi	e			Barba	ara	Stee	ele			
Maryland 21215-0036	2 should be filed within 7 h and Mental Hygiene. 77 is marked other than traumatic event, the M		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Stree	t and Number o	or Rural Route i	Number, City	or Town, State,	Zip Co	de)	
≥ `	and 2 and 2 em Em 27		Kristan Humphries	/ Daughter	903 A	utumn V	iew Cour	rt, Bel	Air,	MD 210	L4		\perp
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Dispo- cemetery, cren	sition (Name of natory or other p	ace)	Date	20c	Location - City	or Tow	n, State	
<u>Ĕ</u>	permit. Page Department o Important: If any injury or once,		4 Donation 5 Other (Specify		atany Git	Ets Regist	ry 07	/25/20		nover,			
at at	permit. Depart Import any inj once.		21. Signature of Funeral Service License	e ~		. Name and Add	,			ts Reg			
<u> </u>	205 20			77-						Hanovei	c , [1D 21076	4
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the dea e cause on each ke.	th. Do not ente	er the mode of dy	ring, such as car	rdiac or respira	tory arrest,			Approximate nterval Between	
F	nysician/		Immediate Cause (Final disease or condition	Sciol	slas?	tomo	M	with	oun	u		Onset and Death	0
	Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		A	7	9				٦
	LXamiller	<u>.</u>	Sequentially list conditions,	b. —							+		-
	p #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	uence of):								1
الألح	ecute and -trans	xar	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	ulence off:						+		-
_	ate be executed ohysician and the burial-transit	dicalE	resulting in death) Educ		1								
200	physic the	edic		d							+		4
687	eath certifical attending ph	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy					23d. Date of	deliver	v.	-
Вох	ath o atten for u	ciar	in the past 12 months?	1 Live Birth 2 Fe	tal death 3	Ectopic pregna Other (specify)				Month		y Day Year	
m	re de / the ched	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown									
P.O.	es that the deal signed by the at I be detached fo	y Pł	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause	given in Part I.	236	. Did tobacc	o use contribute	e to the	cause of death?	١
S,	ires t sign ld be	Completed by							1 🗌 Yes	2 4 No 3 L	Proba	ably 4 🗆 Unknown	
ord	requires been sig should I	lete						24	a. Was an	24b. Were	autops	sy findings available	┨
ec G	e law e has age 2	ш						— L	autopsy performed	? death	1?	pletion of cause of	-
<u>س</u>	n: Th ficate or, pa		25. Was case referred to medical			26	Place of Death		Yes 2	No 1 □	Yes 2	₽ No	
/ita	sicia certi	o Be	avaminar?	lospital:	T EP/Outpation		ther:			6 Other (S)	noniful		1
<u>}</u>	r this eral o	e: To	27. Manner of Death	28a. Date of injury	28b. Time of	28c. lnj	ury at			jury occurred	Jecny)		٦
n O	nding tth. : Afte e fun	cat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury		ork? □ Yes 2 □ No	0					
Sic	lor Attending Physician: The law after death. Director: After this certificate has Jin by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	nome, farm, stre	eet, factory, offic	Э			and Number or	Rural F	Route Number,	7
Division of Vital Records,	al or A s after al Direct			building, etc. (Speci	(9)			City	or Town, Sta	a(e)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		ician: To the best of my knowner: On the basis of examination									$\lceil \rceil$
	To the Ho within 24 To the Fur completel	Me	only one) 3 Certifying Nurs	e Practitioner: To the best of									
_	Voit Con		29b. Signature and title of certifier	1	17	29c. Licer	nse number	005	29d.	Date signed (Mo	onth, D	fiy, Year)	
			1000			11	JUED,	827		112	2/	10	\Box
	d		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, F	Print) L no 6	Phas	a h a -	6.7	W Z.	111	hic MAON	yi
	Y)		31 Date filed (Manth Pair Vac)	40 D	111	your		apea	ICE D	T De	KL	UIMIJAL	4
	Sta	te	31. Date filed (Month, Day Year)	32. Registrar Sign	4 and			/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Sylvia Venezky 2012 0755 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montaomeru If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 577-26-8746 1 M 2 X F 11/03/1923 88 Washington, DC Usual Residence of Decedent be filed within tensor shall be filed within tensor shall be shall or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Funeral 13613 Colefair Drive 20904 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental H is marked o ပ္ Samuel Fine Esther Phillips Department of Health and Inportant if item 27 is m any injury or other traumsonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Fine - Nephew 12617 Council Oak Drive, Waldorf, Maryland 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 07/27/2012 Judean Mem. Gardens Olney, Maryland 21. Signat e of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. icer see MOOTO 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failers. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Metastatic Breast Cancer certificate be executed and Due to (or as a consequence of) ŵ resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death ped the 9 Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 X 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 \sum Yes 2 XNo ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: X Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead in bouried at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) usse D69288 July 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Acquistrar

Yodit Negusse, M.D.,

6 2012

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ weaverling Month 5 George 2012 Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Cecil 160 S. Shore Rd. Elkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) June 23, 1942 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Pennsylvania Director 172-34-9106 1 X M 2 - F 70 if lead 2 should be filed within 72 nous and if leads and Mental Hygiene. It health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "defical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21921 USA 160 S. Shore Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 X Married <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) master craftsman Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname ೭ Lillian Jane Hand William Lester Weaverling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 S. Shore Rd; Elkton, MD 21921 Frances Weaverling - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Ronald Virector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition T- Cell Ly mphoma Onset and Death Priysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease of Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 24 hours after death. filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗖 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director of completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated nskaj apaklm 29b. Signature and title of certifie 00057465

State Registrar mim

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Rajnpaksemo

31. Date filed (Month, Day, Year)

5203 Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Jason Willard W			Stat	e of Maryla				nd Men	tal Hygie	ene	,	001	2 227
Dhoraini		I - For State Registrar 1. Decedent's Nam	e (First Middle I	ast)	Ce	rtificate of	Death		12.D	Re ate of Deat	eg. No. C	U	3. Time of Death
Physicia Medical Exami				Williams	5				Ju	onth Iy 17, 20	Day Yea	ar	1146 hrs
		4a. Facility Name (i		give street and nu	mber)	- 4	b. City, Town, o		of Death		4c. County Carroll	of Death	
Europol		5. Social Security N		Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		er 24Hrs. 8.	Date of Birl		/) 9. Bir	thplace (State or
Funeral Director		or goodan goodan,		[X]м 2_F	45	Yrs	Months Da	_	Min		1966	Foreig	
	ŀ	Usual Residence o							1 1				
w any			10b. County			, Town or Locati							10d. Inside City Limits 1 Yes 2 No
yland -f sho	후	MD 10e. Street and Nu	Howa	rd	M;	arriotts	10f. Zip Code			110	0g, Citizen of W	hat Cour	A
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with that and 23a		11. Marital Status			cedent Ever in U		s Decedent of H						can Indian, Black,
death	Funeral	1 Never Marri		1 Yes	2 X No		es, specify Cuba		, Puerto Rical	n, etc.)		e, etc.	
rs after	à.	3 Widowed 15. Decedent's Ed		or Dates:			Yes 2 X N t's Usual Occup		kind of work of	lone	Specify:		
72 hou	eted	Elementary/Seco		College (1		during me	ost of working lif	e. DO NOT	use retired)				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Media	Completed	12			0	land	scaper				lands		ing
filed w Hygid d other		17. Father's Name									Maiden Surname	*)	
212 ould be Menta marke	To Be	Karwell 19a. Informant's Na	Willia me/Relationship	ms (Type, Print)		19b. Mailing	Address (Stre		anita I nber or Rural		ber, City or Tow	vn, State	, Zip Code)
MD d 2 sho ith and n 27 is		Timothy	Willia	ms - bro	ther	241	6 Fores	t Hill	L Rd; N	larri			MD 21104
re, leg land f. Heal		20a. Method of Dis		3 Removal fr		Place of Dispos crematory or oth		emetery,	Dat	е	20c. Location	- City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Spec	ity: in sta	ite								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury or nither traumatic event, the Medical Examiner must be notified at once.		21. Signature of Eu	neral Service Li	wade, I	irecto	r .					omy Boa timore,		21201
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, Wedical Examiner	l	failure. List on Immediate Cause (ly one cause or Final disease	a. Contact Gu	ınshot Wou	nd of Head							Death Death
Examine		or condition resulti	ng in death)	•	consequence	of):							
	<u>ē</u>	Sequentially list co	nmediate	b. Due to (or as a	consequence	of):							
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executed an and al - transit		events resulting in	death) Last	d	<u> </u>								
al exe	dical	UNPENDED		AMENDED									
Box 68760 e death certificate be the attending physical for use as the bu		IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes,	outcome of pre		tal death 3	Ectopic	c pregnancy		23d. Date of Month		y Day Year
x 68 th certi	icia	past 12 months		4 Pregr	nant at time of d		her (Specify)				19		
. Bo the dea y the a	Phys	Part II. Other signi		9 OHKI		resulting in the u	inderlying cause	given in Pa	ert I	23e. Did to	bacco use conti	ribute to	the cause of death?
P.O. es that the igned by	2	Tare in Outside Sign		oonangaang c				3		1 Yes	s 2 🗸 No 3	Prob	pably 4 Unknown
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ecol he law ate has	dmo	-	_								rmed?	death?	
Vital Rec ysician: The l his certificate l director, page	0	25. Was case refer	red to medical				26. Pla		(Check only				
of Vit ing Physici After this c	10 B	examiner?	2 No		Inpatient 2	ER/Outpatient					Residence 6 how injury occur		r: Scene
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Division of Vital Records, at a or attending Physician: The law requirers after death. To allorector: After this certificate has been sited in by the funeral director, page 2 should be	ficat	2 Accident 3 Suicide	Investi	gation 28e Plac	ce of Injury - At I	home, farm, stree	et, factory, office	building, et	tc. 28f.			er or Ru	iral Route Number, City
DIVI spital or cours after	Certification:	3 Suicide 4 Homicide	determ		Yard		<u></u>		2416	or Town, S Forest F	itate) Iill Road, Marr	iottsvill	e, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier (Check only one)		sician: To the be									
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	===	2-2)					C.M.E.			July 18, 20		
	ŀ	30. Name and add	ress of person w								L		
			/incenti, MD			miner 900	W. Baltimoi	re Street,	Baltimore	, MD 21	223		
St Regis		31. Date filed (Mon	2 6 2012	Baseura.	egistrar's Signa	barre							

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		4	State of Maryla		irtment of H <i>tificate of D</i>			0/	3 1 0	00707
-			Registrar 1. Decedent's Name (First, Middle, Last)	Ceri	uncate of D	eatri	2. Date of Deat	eg. No.	116	3. Time of Death
	Physicia	n/	James Wilkins				July	16 2	2012	4:07 ₽ ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County		
0			Country Living 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Poolesv	If Under 24 Hrs.	8. Date of Birth	Mon	ace (State or Foreign	
	Funeral Director		231-44-9498 1 M M 2 □ F 76	Yrs.	Months Days	Hours Min.	Sept 27	, Year) 935		ginia
	d tow		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Loc	cation		l		10	Od. Inside City Limits
	arylan ta-f sh ified a	ecto	MD Montgomery	Pooles						1 ☐ Yes 2 🙀 No
	the M	ᄒ	10e. Street and Number		10f. Zip Code			10g. Citizen of \	What Coun	try?
	h with	Funeral Director	PO Box 14	Lo Tro v	20837		sift Vac ar No	USA		Indian
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1	If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white		
5-0	2 hour "natu	plet	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa	ition uring most of work	ring	16b. Kind of B	usiness/Inc	_{lustry} unk
121	ithin 7, ene. r than	Com	Elementary/Secondary (0-12) College (1-4 or 5+)		physics					
d 2	al Hygi I othe vent,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam				
ylar	Menta Menta narked	은	James Alexander Wilkins				s Marie			
Mai	2 shoulth and lth and 27 is n		19a. Informant's Name/Relationship (<i>Type, Print</i>) Ellie Ahan – POA		ng Address (Street a				state, ZIP C	ode)
Baltimore, Maryland 21215-0036	Page 1 and lent of Hea nt: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 【X Donation 5 ☐ Other (Specify)	**	natory or other place	e)	Date	20c. Location		wn, State
Balti	permit. F Departm Importa any inju		21. Signature No. geral Servicensee Direct	or 22	. Name and Addres	s of Facility St Baltimore	ate Anat St; Ba	omy Boa Ltimore	ard , MD	21201
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68760	ificate ig phy as the	Medi	IF FEMALE.							
30X	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	у			ate of delive	ery Day Year
ls, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.		Part II. Other significant conditions contributing to death but not	resulting in the u	ınderlying cause giv	ren in Part I.	23e. Did to	_		ne cause of death?
Division of Vital Records,	The law req ate has bee page 2 sho	Completed by					24a. Was a autop perfo 1 Yes			osy findings available impletion of cause of 2 XNo
ta	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I pagatient 2		Oth	ace of Death (Chec		· Stou		Grow home
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ou	eath. or: Afte he fun	ficat	Natural 5 Pending (Month, Day, Year, 2 Accident Investigation) injury	M 1 🗆	Yes 2 No				
Divisi	tal or Atterns after de al Directoled in by t	al Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe	cify)			28f. Location (S City or Tow	n, State)		
	the Hospi hin 24 hou the Funer npletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2	ation and/or inves	tigation, in my opinion, death occurred at t	on, death occurred a the time, date and p	at the time, date a place, and due to t	nd place, and di he cause(s) and	ue to the ca manner as :	use(s) and manner stated. stated.
	Neitl Sor		29b. Signature and title of certifier		29c. Licens	number		29d. Date signe	-	2c/2
			30. Name and address of person who completed cause of death (I		Print)	erman	toun	WA		
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 6 2012							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Carolyn Ann White 2012° 24 July 7:15 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7860 St. Bridget Lane Dundalk Baltimore Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min Hours **Director** 216-30-7292 1 □ M 2**X** F 79 Yrs. December 1,1932 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2 XNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7860 St. Bridget Lane 21222 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Order Processer H&S Bakery 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Strickland Mary Catherine Dorsey other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, James William White Sr. Husband 7860 St. Bridget Lane, Dundalk, Maryland 21222 t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus uly 26, 2012 20c. Location - City or Town, State tment of 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Dundalk, Maryland Signa ure of Fune I Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. ot enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ sofathic Parkinsun's Discuss disease or condition resulting in death) Medical **Examiner** Esqueritially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery e past 12 months? Yes 2 No Ectopic pregnancy for in the past 12, Other (specify) Month Pregnant at time of death Day Year should be detached q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Squere Haspital 9000 Franklin Square Or.

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	Funeral Director		5. Social Security Number 554687347	6. Sex 1 □ M 2 🂢 F	7. Age (In yrs. Ias	t birthday)	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da		15	9. Birthp Count	lace (State or Fo	_
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	laryla 3a-f s iffied	ect	MARYLAND PRIN	E GEORGE	R TE	MPLE	Hius								1 XYes 2	□ No
	the A or 2	ق	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of W	/hat Coun	try?	
	s 23a	Funeral Director	8601 TEMPLE F	tills Ro.	LOT #49		ć	70R	48				USA	ς		
	death item	Fur	11. Marital Status	12. Was Dec	cedent Ever in U.S. forces? a 2 XNo	13. \	Was Deceder f Yes, specify	nt of Hi	spanic Origi n, Mexican,	in? (Speci Puerto R	fy Yes or No- ican, etc.)			- Americ		
36	after I", or xami	d by	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, G	ive		I ☐ Yes 2	No	Specify:				Specify:	BLA		
S	atura cal E	Completed		Q Year or I ent's Education	Jates.	16a. Deced	dent's Usual (Occupa	ation			16b. K	(ind of Bu			
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Box	eath (icia	in the past 12 months? 1 ☐ Yes 2 🗙 No	4 □ Pre	egnant at time of de	death 3 L eath 5 D	☐ Ectopic pre☐ Other (spec						Mor	nth	Day Year	r
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/ Division of Vital Records, P.O.	Atter ir dea sctor	Certificate:	3 Suicide 6 Coul	d not be 28e. Pla	ce of Injury - At hor	ne, farm, str	eet, factory,				8f. Location	(Street ar	nd Numbe	er or Rural	Route Number,	
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_	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burneral filled in by the funeral director, page 2 should be detached for use as the burneral director.	Medical	29a. Certifier 1 Certifyir (Check 2 Medical	ng Physician: To the Examiner: On the b	best of my knowle	edge, death	occured at th	ne time	, date and p	olace, and	due to the c	ause(s) a	nd manne	er as state	d. use(s) and manne	er stated
	the H hin 24 the F	₩ W	only one) 3 Certifyir	ng Nurse Practione	r: To the best of my	knowledge,	death occurre	ed at th	e time, date	and place	, and due to t	he cause	(s) and ma	nner as st	ated.	
_	5 Viti		29b. Signature and title of certifi	1/ June	Onto				e number				ate signed		-	
	•		With			00-1/7		გხა	206			4	28/	901,	7	
1			30. Name and address of person WILLIAM T.						A1.00	. Ht.	I Fra	TW1	معياء	1. HT.	, MD 2	07111
	Sta	te	31. Date filed (Month, Day, Year)	32.			4	<u>ی ری</u>	TIP TIP	16	1 1 5 6	-, IV	अता	<u> </u>	- (11 e	V144
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DHMH 17 Rev 7/2009

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AMEND ITEM#23a,pt1,perPHYS,G929,7726/2012,WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WRIGHT Day MORRIS N. Year 2012 13 Medical 4c. County of Death

ANNE ARUNAEL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASKINGTON MEDICAL CENTRE MO BALTIMORE GLEN BURNIEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 579-72-8203 1 🛛 M 2 🗆 F 55 1956 Washington, D.C Usual Residence of Decedent July 29, 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Glen Burnie <u>Maryl</u>and Anne Arundel 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 631 Baylor Road 21061 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Was Decedent Ever III 0.3.

Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates 1975—1995 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Completed Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Military Soldier United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic e Nancy Lydia Morris Thomas Nathaniel Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 Baylor Road Glen Burnie, Maryland 21061 Janice I. Wright / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 18, 2012 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Donaldson Funeral Home & Crematory, Donaldson Funéral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 WillE 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Sepsis** Approximate Interval Between Onset and Death 2 days Immediate Cause (Final Pnysician/ muct (put ORGAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Disseminated Intravascular Coagulopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Renal failure that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Rhabdomyolysis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြု 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00044402 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVE MD . 301 Hospital Drive Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) State 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

illonah Yancey		1- For State Registrar	ate of Maryla	•	artment of rtificate of		d Mental I	• -	eg. No. 2	012 2	2379
Physiciai Medical Examin	-	1. Decedent's Name (First, Middl Allonah Yan	le,Last) ICEY	_				2. Date of Dear Month July 16, 20	Day Year	3. Time of I	
		4a. Facility Name (if not institutio Harbor Hospital Cente		mber)		4b. City, Town, or Baltimore	Location of Dea		4c. County of	Death	
Funeral Director		5. Social Security Number 150-29-4986	6. Sex	7. Age (In yrs. i	ast birthday) Yrs	If Under 1 Year Months Day		in	th(MM/DD/YYYY) 5/2011	Birthplace (State Foreign Country) MD	
any	ł	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	on				10d. Inside	City Limits
Maryland 28a-f show	اق	MD N/A	1	Ва	altimo						2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 2353 Seamon	Ave.			10f. Zip Code 21	225	11	Og. Citizen of Wha	t Country?	
	y Funeral		arried 12. Was Dec Armed Fo 1 Yes orced If Yes, Give Yea	2 X No	If Y	s Decedent of Hises, specify Cubar Yes 2 X No	n, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - White, Specify:	American Indian, E etc. Black	Black,
hours a	ed by	15. Decedent's Education (Spec				t's Usual Occupat			16b. Kind of Busi	ness/Industry	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) N/A	College (1 N/A	-4 or 5+)	N/				N/A		
21215-0036 ould be filed within 7 Mental Hygiene. I marked other than it event, the Medica	Se l	17. Father's Name (First, Middle, Shawn Yanc						ne (First, Middle, M Wingfi			
MD 21 d 2 should lth and Me n 27 is ma		19a. Informant's Name/Relations Atina Wingfi		ner					ber, City or Town, ore, MD		
s 1 and of Healt	Ì	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fro	om State	crematory or oth	tion (Name of cer		Date	20c Location - C Baltimo	City or Town, State	
Baltimore, pernit. Pages 1 a Department of He Important: If ite injury or other tr	ŀ	4 Donation 5 Other Sp 21. Signature of Funeral Service		1 111	22. N	ame and Address	of Facility	March I	'/H- Ea:	st	
Physician	+	23a. Part I. Enter the disease, or		aused the death.					Ltimore est, shock, or hear	•	ate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		nexpect consequence o	ed Deat	h In Infa	ncy (SIID	Ι)			Onset and eath
13	<u></u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence o	f):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	f):	_		_			_
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60, rate be exe physician a ne burial -	Med	F FEMALE:	23c. If yes, c	20c, perFH outcome of preg		6/2012,WS			23d. Date of de	elivery	
Box 68760, ne death certificate be executed the attending physician and ned for use as the burial - transi	<u>a</u>	3b. Was decedent pregnant in th past 12 months?	4 Pregna	rth ant at time of de	ath -	al death 3 [ner (Specify)	Ectopic pregr	nancy	Month	Day	Year
BO) he deat	Fnys	1 Yes 2 V No 9 Unk	9 Unkno					Logo Did to	bacco use contribu	to to the course of	E death 0
ires that the signed by I be detach	2	rart II. Other significant conditi	ons contributing to	death but not re	esuiting in the u	nderlying cause g	iven in Part I.		2 No 3		
cords law requir	Completed							24a, Was a	sy prio	ere autopsy finding or to completion of	
Vital Recysician: The Linis certificate his director, page		25. Was case referred to medical				26 Blace	of Death (Check	perfor 1 ✓ Yes 2		ath? ✔ Yes 2 [No No
Vital hysician this cert		examiner? 1 ✓ Yes 2 No	70 N N N N N N N N N N N N N N N N N N N	npatient 2	ER/Outpatient		Other -		Residence 6	Other Other	
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beautified.		2 Accident Inves 3 Suicide 6 X Could	tigation 28e. Place			t, factory, office b		28f. Location (S	treet and Number ate) 622 Hil		
Hospital Hospital Hospital Hospital Hospital		4 Homicide	mined (Specify) ysician: To the best	Fd:Resi		ed at the time. da	ite and place, an	Brookly	n,MD.		•
To the Hos within 24 h To the Fun completely			miner:On the basis o and manner st	f examination a		on, in my opinion	, death occurred		and place, and due	e to the cause(s)	
	-	Signature and the or certified				29c. License O.C.I			July 17, 2012	(Month, Day,Yea 2	v)
i oxpera	1	M. Name and address of person		•		A/ Dalliman	Stroot Daliti	more MD 241	222		
Stat	œ :	Russell Alexander MD 31. Date filed (Month, Day, Year)		edical Exam gistrar's Signatu			otreet, Baltii	more, MD 212	223		
Registra		JUL 26	2012 De	wa ,	a. ga	Ked			IVIE		<u></u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death July 2012 Helen Pauline Zimmerman 9:25 am 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Hours 1 □ M 2 🕱 F 88 May 27, 1924 Illinois

for State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner Social Security Number **Funeral** 340-28-0405 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sl notified a Silver Spring Maryland Montaomeru ige 1 and 2 should be filed within 72 hours after death with the lost the death and Mental Hygiene.

If it fem 27 is marked other than "natural", or items 23a or 2 is other traumatic event, the Medical Examiner must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11629 Lockwood Drive, 20904 Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed Specify 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Dora Cameron Fred Huls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa A. Peterson - Daughter 4202 Red Cedar Lane, Burtonsville, Maryland 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lincoln Crematory 07/26/2012 Brentwood, Maryland 4 Donation 15 Other (Specify) re of up ral av 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Sign 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 🕽 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Large Intracranial Hemorrhage Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires

23d. Date of delivery Month

24a. Was an autopsy ☐ Yes 2 🗶 No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

July 19, 2012

10d. Inside City Limits

White

Interval Between Onset and Death

U.S.A.

1 Tes 2 X No

25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

28a. Date of injury (Month, Day, Year) 1 🛛 Natural 5 Pendina Accident Investigation 6 Could not be Suicide 4 Homicide

injury work? 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

D65069

City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Cartifyir Cot the to 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, Maryland 20910 Sirak Hagos Lemma, M.D., 31. Date filed (Month, Day, Year)

State Registrar

has

certificate !

filled in by the funeral director,

completely

24 hours after deat Funeral Director:

Be

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Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2013 Physician/ Month Jaca M 9 OF: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Burnie Anne Medical Washing ton cente If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) . Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs 218-24-9514 Director 1 □ M XX F 86 7/26/1925 Baltimore, MD 28a-f show 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes XX No MD Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 305 Patsy Avenue 21060 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2XXMarried ō Yes Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give "natural" Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Peter Kowalski, Sr. Stella Brocki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is any injury or other trainmone. Mr. Walter J. Zeun / Husband 305 Patsy Avenue Glen Burnie, MD 21060 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation XX Other (Specify) Entombment St. Stanislaus 7/28/2012 Dundalk, MD 21. Signatur o Funeral ervi Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COPD disease or condition 20 YEARS Medical resulting in death) Due to (or as a consequence of): Examiner YOYEARS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ res ∠ . 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CKD 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 🗌 Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No မ 1 Nation 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death. neral Director: After th y filled in by the funera Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Funeral Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completely fi 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier an cool dugs out mulling VIF52000

Registrar

State

CUILLENMO JOSE CIANCRECO 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161-5803

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:42 AM w Medical 4a. Facility Name (if not institution, give street and nur. **Examiner** Town, or Location of Death 4c. County of Death - Hellar no 5. Social Security Number . Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 1 🗆 M 2 🕮 Director 219-12-5019 Yrs. 86 SEPT. 28 1925 SOUTH CAROLINA Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No ANNE ARUNDEL CO MARYLAND GLEN BURNIE 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7885 GORDON CT., S.A APT 522 21060 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2X No Specify: "natural", Specify: BLACK Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12yrs LABORER PRIVATE traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ MACEO PINKNEY ROSABELLE PINKNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is unique or other train. 21061 Venessa Wright/Daugther 456 Old Quarterfield Rd., Apt D12, Glen Burnie, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 08-04-12 LANSDOWNE, MARYLAND 21. Signature of Juneral/Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE, BALTIMORE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STIVE HEART FAILURE Immediate Cause (Final Onset and Death Physician/ 116t (9 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? signed by the atte Month Day Year Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy -2 Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 ER/Outpatient 3 DOA Inpatient 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

7

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Albi 02:15 aM N. Remo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A <u>5415 Summerfield</u> Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) Months (Month, Day, Year) 04/01/1932 213-28-5636 1 🔀 M 2 🗆 F **Director** 80 Usual Residence of Decede 28a-f show 10c. City, Town or Location 10a. State at 10d. Inside City Limits the Maryland Funeral Director notified MD N/A **Baltimore** 1 X Yes 2 No 0 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code must be 23a with U.S.A. 21206 5415 Summerfield Avenue items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status ural", or iten 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. β 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify White "natural", Completed I 3 Widowed 4 Divorced Year or Dates Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Plasterer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albi Luigi Concetta Saia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 619 Shore Drive Joppa, MD 21085 Ronnie J. Albi, Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Svc. Corp. 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State 07/28/12 Towson, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Demandra Dair 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events attending physician and I for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Year Month Day signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed 2 No 1 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ti 29d. Date signed (Month, Day, Year)

Registrar

100

30. Name and add

alto MD 21237

mpleted cause of death (Item 23a) (Type, Print)

hiladel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Fakhredin Asrari 12:05P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 198**-**74-8269 1 X M 2 □ F 84 Oct. 06, 1927 Iran 10d. Inside City Limits 10b County 10c. City, Town or Location other traumetic event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Lutherville 23a or 2 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 61 Seminary Farm Road 21093 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. 1 ☐ Never Married 2 X Married 2 ☐ Yes 2 1 No 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes. Give 3 🗌 Widowed 4 🗆 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other transmits. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Soldier Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Mohammad Asrari Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fariba Asrari/ Daughter Seminary Farm Rd. Lutherville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulanev Vallev Mem. 7-28-12 <u>Timonium, MD.</u> 21. Signature of ^{22. Name and Address of Facility} Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de <u>۾</u> 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No ☐ Yes 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MOSPLY 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No thef Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title 29c. License number 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 ALLES MD 201 Tonson T

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 26 2012 EDITH M. BECKER 8:25A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Woodlands Assisted Living Middle River Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 8, 1922 **Funeral** . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Country) Hours 89 217-26-9253
Usual Residence of Decede Director MD. 1 🗆 M 2**X** F 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland | Baltimore 1 Yes 2x No Baltimore County 10e Street and Number ms 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5218 Kenwood Avenue 21206 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. one. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Furniture Industry Elementary/Secondary (0-12) College (1-4 or 5+) 7th Grade N/A Sales Clerk <u>Levinson & Klein</u> Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick William Marx Emma W. Christ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip H. Becker (Son) 3634 Hoffman Mill Rd. Hampstead, Md. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 7-28-2012 Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home assakn 7401 Belair Rd. Baltimore, Md. 21236 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 2 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Known menos Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) Month Day Year a Hinknown g Unknown ò signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Hospited Li မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State

DHMH 17 Rev 06-2011

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M.D.

7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

709.

WASEBM.

BASTERN

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BLVD

29d. Date signed (Month, Day, Year)

21221

M.D -

26-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 1:44PM rown 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner altimore man If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Country) Hours (Month, Day, Year) -18-4838 Director 1 M 2 F 96 1916 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Blac Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mac (VI) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie thisia Hole IVVICAME 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Byrial 2 Cremation 3 Removal from State 28 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Hom JULY MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury Examine Due to (or as a consequence of) attending physiclan and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗆 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death Day Year cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No. 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s perform 2 🗌 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) work? 1 Yes 2 No 5 Pending Investigation 6 ☐ Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖫 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifie 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23800 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07/22/2012 Physician/ Sarah Ada Blumenschein 2:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Burnett Calvert Hospice House Calvert Prince Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/23/1922 Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Country) Director 224-26-3108 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Owings 1 🗷 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1126 Somerset Ln. 20736 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Patton Nickels Nellie Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Blumenschein / Husband 1126 Somerset Ln Owings MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 07/24/2012 Bethesda, MD Uniformed Service M00382 Rapp ar Address of a and Cremation Services total down 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between each line shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner 2011 Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine 1990 attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal dea 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Be Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after death. Funeral Director: After this certificate has page 2 2 No 1 Yes funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) ပ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation completed filled in by the 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. only one the

X DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certif

as

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANSON M

29c. License number

137 MITCHELL'S CHANCE RD. EDGEWATER

0036242

29d. Date signed (Month, Day, Year) 26

21037

1	2-	05403	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Thomas Brady		1- For State Registrar	Stat	e of Maryla		partmen <i>Certificate</i>			l Ment	al Hyg		eg. No.	20	12 238
Physician/ Medi Exami	cal	1. Decedent's Name									2. Date of Deal	nth Day	/ear	3. Time of Death
)		THOMAS JO 4a. Facility Name (in	f not institution, g	give street and num	iber)			ity, Town, or L	_ocation of		July 18, 20	4c. County		h
- Eumanal		Greater Laurel 5. Social Security N			7 Age (In v	ırs. last birthda	Laur	rel Under 1 Year	If Under	r 24 Hrg	a Date of Bit		Georg	e's rthplace (State or Foreign
Funeral Director		578-36-28	823 1	1 M 2 F	I. Age taly	84		onths Days	_	Min.	1	6-1927	GE	ountry) ORGIA
yns	1	Usual Residence of 10a. State	Decedent 10b. County		10c. (City, Town or L	Location							10d. Inside City Limits
Maryland 28a-f show any dat.once.	5	MD		GEORGE 1	S BC	OWIE								1 XYes 2 No
ne Maryli or 28a-f	Director	10e. Street and Num 11528 WA		D				. Zip Code 0721			1	l0g. Citizen of V USA	vhat Cou	ntry?
with the ns 23a or notif	ralD	11 J26 WA	NOCILL D.	12. Was Dec		n U.S. 13	3. Was Dec	cedent of Hisp			cify Yes or No-	- 14. Rac		rican Indian, Black,
11215-0036 Id be filed withn 72 hours after death with the Maryland Jental Efgiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Funeral	1 Never Marrie		1 Yes	2 X N	lo		pecify Cuban,		Puerto Ri	ican, etc.)		nite, etc. BLA	CK
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6 n 72 ho lan "na ical Ex	Completed	Elementary/Seco		College (1-		dun		working life.	DO NOT us	se retired	1)	PRI	VATE	
-003 d within ygiene. other th	omi	12 17 Father's Name (I	First, Middle, La	st)		A	AT &		18.Mother's	Name (F	irst, Middle, M	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	GEORGE M	CCLOUD								GRIFFI			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Departnet of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shr injury or other tranmatic event, the Medical Examiner must be notified at once	입	19a. Informant's Nar PATRICI.					dailing Addr 528 W.				ral Route Num E,MD 2	nber, City or To 20721	wn, State	, Zip Code)
re, N I and if if Health if item	1	20a. Method of Disp	osition			0b. Place of Di crematory	Disposition (or other pl	Name of ceme	etery,	ſ	Date	20c. Location	ı - City or	r Town, State
Baltimore, pernit. Pages I at Department of Hes Important: If the injury or other tr		4 Donation 5	Other Spec	cify		LINCOL	N CEM	ETERY			/2012			MARYLAND
Balt permit Depart Impor injury		21 Signature of Fur	ut N.	Cornol	lille		74	74 LAN	IDOVEL	R RD	HYATTS	SVILLE.	MD	HOME, INC 20785
Physician Idealical		23a. Pad I. Enter the failure. List onl	e disease, or con y one cause on				ter the mod thero	e of dying, su sclero	ch as card	diac or res card	spiratory arres	st, shock, or he ular	art	Approximate Interval Between Onset and
Examiner		Immediate Cause (F or condition resulting		a disease Due to (or as a	comp1	icating se of):	g dia	Lysis p	roced	dure	forende	stage ren	ıldis	ease Death
	_	Sequentially list con if any, leading to im		b	consequenc	e off:								
	Examine	cause. Enter Under (Disease or injury th	rlying Cause nat initiated	C	· ·									
executed an and al-transit		events resulting in d	sath). I est	Due to (or as a d.										
9 77 6	Medical	X UNPENDED				.II,27,	per 1	ne,g93	1 9-2	<u> 28–12</u>	. sm			
2 8 E		IF FEMALE: 23b. Was decedent p past 12 months		23c. If yes, o		oregnancy 2	Fetal de	ath 3	Ectopic	pregnanc	у	23d Date of Month		y Day Year
i, P.O. Box 68' ures that the death certifi signed by the attending the detached for use as!	Physician/	1 Yes 2 N		1 ' L	ant at time of wn	f death 5	Other (Specity) _						
on the defactor of the detached		Part II. Other signif	icant condition			ot resulting in t	the underlyi	ng cause give	en in Part I	l.		_		the cause of death?
S, P.	ed b	<u>Diabete</u>	s Melli	tus and	hyper	choles	<u>terol</u>	emia				s 2 No 3		bably 4 X Unknown
Cord	Completed by										24a. Was autop	osy ormed?	prior to death?	utopsy findings available completion of cause of
I Re n: The rtificate		25. Was case referr	ed to medical	T				26 Place	of Death (C	Check on	1 X Yes	2 No	1 X Y	es 2 No
Vita hysicia this cer	0 B	examiner?	2 No	Hospital: 1 I	npatient 2	X ER/Outpa	atient 3	DOA	Other 4	Nursing I		Residence 6	Other	r:
O So 2 So 1 27. Material of Death 200. Third of Highly 200. Third of Hig							yatWork? es 2 [] t		8d. Describe t	how injury occu	rred			
1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Rou or Town, State) 1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Rou or Town, State) 28g. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28f Location (Street and Number or Rural Rou or Town, State) 28g. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								ral Route Number, City						
4 Homicide (Speciny) 29a. Certifier 29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
H Z d d d l Coheck only one 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Coheck only one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
	Σ	29b. Signature and t	itle of certiner	11				29c, License O.C.M				July 19,		onth, Day, Year)
	ŀ	30 Name and addre	ess of person wh	no completed cause			/							
X		Theodore M		AD. Assistan	nt Medical	Examiner	900 V	V. Baltimor	re Street	t, Baltin	nore, MD 2	21223		
St	ate	31. Date filed (Mont	7 2012	Charles 32 Rg	gistra	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\mathtt{July}^{ ext{Month}}$ Physician/ Matilda Frances Bowman 22 10:50 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 Huntington Place Harford Bel Air Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year, **Director** 202-24-5298 82 July 7, 1930 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director ↑1 ☐ Yes 2 No Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Huntington Place 21014 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3X Widowed 4 ☐ Divorced Completed White Year or Dates intal Hygiene. Red other than "natura s event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed. Department of Health and Mental Humportant: If item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Wilbur Zerbe Merle (unk) Seiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benny Bowman / Son 3711 Aldino Road, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7-25-2012 Rose Hill Svcs, LLC 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland re of Funeral Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. esseca of Wealth 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Dea h Immediate Cause (Final Physician/ Cancel disease or condition Medical resulting in death) Due to (ir as consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ó in the past 12 months Pregnant at time of death detached Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate by 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 8 41 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahrani, M.D.500 Upper Chesapeake Drive, Bel Air, Maryland 31. Date filed (Month, Day, Year) 7 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I- For State Control of Waryland / Department Control of Certificate Of Registrar		Reg. No.	12 2381
Physicia lical Exami	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year No. 24, 2013	3. Time of Death 0638 hrs
ICAI EXAIIII	mer	GEORGE JERRY BEACH, SR. 4a. Facility Name (if not institution, give street and number) 3908 Walters Road	4b. City, Town, or Location of Dea Edgewood	th 4c. County of Deat	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220-38-8249 1X M 2 F 68 Yrs	If Under 1 Year If Under 24H Months Days Hours Mi	Toroi	ian
япу		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion		10d. Inside City Limits
Maryland 28a-f show 1 at once	for	MD HARFORD EDGEWOO		10g. Citizen of What Co.	1 Yes 2 X No
h the Maryland 3a or 28a-f sho	Director	10e. Street and Number 3908 WALTERS ROAD	10f. Zip Code 21040	USA	anti y r
ath with items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Never Married 2 K Married Armed Forces?	as Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Puer		rican Indian, Black,
after de	by Fu	or Dates:	Yes 2 No specify:	Specify: WH	
be filed within 72 hours after death with the Maryland nital Hyggiene. rked nther than "natural", ur items 23a or 28a-f shent, the Medical Examiner must be notified at once	Completed I	Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation (Give kind or ost of working life, DO NOT use re	etired)	/Industry
uld be filed within 7 Mental Hygiene. marked nther than c event, the Medica	Som	8TH ROOF 17. Father's Name (First, Middle, Last)		ROOFING ne (First, Middle, Maiden Surname)	
d be file lental H arked r event, il	Be	LLOYD J. BEACH		Y V. AMBROSE	a Zin Coda)
id 2 shoul lith and M m 27 is m	ဍ		(-	EDGEWOOD MD. 21040	
		2C.a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other state.	25.7728	Date 20c, Location - City o	
permit. Pages l ar Department of Hec Important: If ite injury or uther tr	4	21. Signature of Funeral Service Licensee 22. N	lame and Address of Facility	28-2012 BEL AIR, SCHIMUNEK FÜNERAL H	OME OF BEL
		23a. Part I. Enter the discass, or complications that caused the death. Do not enter to		ROAD BEL AIR, MD. 2	1014 Approximate Interval
hysician Wedical xaminer		failure. List of one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Card Due to (or as a consequence of):			Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			-
ited d ansit	Examiner	(C) Sease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
oe executed ician and irial - trans	Wedical	UNPENDED AMENDED			
The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		past 12 months?	etal death 3 Ectopic pregi	nancy 23d. Date of deliver	ry Day Year
at the de d by the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	
quires that the	ted by	Diabetes Mellitus		1 Yes 2 No 3 Pro	obably 4 Unknown utopsy findings available
The law requirate has been page 2 should	Completed			autopsy prior to performed? death?	completion of cause of
ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Chec	k only one) sing Home 5 Residence 6 ✔ Othe	or: Coopo
ing Ph After t funeral	n: To	27. Manner of Death 28. Date of Injury (Month, Day, Year) (Month, Day, Year) 28b. Time of I		28d. Describe how injury occurred	er. Scene
To the Hospital nr Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre		28f. Location (Street and Number or R or Town, State)	tural Route Number, City
Hospital 24 hours Funeral etely filled		4 Homicide determined (Specify) 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occur			
To the within To the comple	Medical	one) 2 Medical Examiner: Dn the basis of examination and/or investigal and manner stated. 29b. Signature and title of certifier	29c. License number	d at the time, date and place, and due to t 29d. Date signed (Me	
Jan L	-	Pate an- Poller	O.C.M.E.	July 24, 2012	
1 0		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	900 W. Baltimore Street,	Baltimore, MD 21223	
S	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year July 21, Audrey Battersby 10:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Riverside Be1camp Harford Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. 5/12/1929 Director 214-24-8166 83 Maryland 1 🗆 M 2 🗶 F Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XIXX Yes 2 No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Completed by Funeral 200 Kane Street Apt. 408 21224 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Specify: White 3 XXidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacob Stella Eigner SCHANE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Patricia E. Appel (dtr) 1301 Ruthridge Court Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Sacred Hrt of Jesus 07/25/12 Baltimore, Maryland 4 Dogation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. of Funeral Service License Signatu 9705 Belair Rd. Nottingham, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Crehnorauc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MACHACI Sequentially list conditions. transplacements to in mediate cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of): ysician a e burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Yes 1 | Yes 2 | 9 | Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? this certificate 1 ☐ Yes 2. No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 TN Nursing Home 5 - Residence 6 - Other (Specify) 1 🗌 Yes 2 😘 No ည 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this ed in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Dis completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

only one

29b. Signature and title of certifier

30. Name and address of person who

2

7 2012

MACPHA

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:45 AM DONALD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Himore Medical 2nk 6. Sex **Funeral** 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country DISTRICT OF Director 1 ☑ M 2 ☐ F 28a-f show with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No ANNEARUND 10e. Street and Number ō 10g, Citizen of What Country? Funeral items 23a 21122 U.S.A. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or ģ If Yes, Give Year or Dates 1 Yes 2 No Specify: WhITE Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK and Mental ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 FLORENCE A. BRANDT, WIFE per it. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Method of Disposition 20b. Place of Disposition (Name of 1 🗆 Burial 2 🕶 Cremation 3 🗆 Removal from State cemetery, crematory or other place) CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) DENTON 22. Name and Address of Facility DAUGHERTY FUNERAL HOME 2601 MOUNTAIN RD. MIGATIEN 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a second at caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of, cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ☐ No 3 🔀 Probably 4 ☐ Unknown page 2 should Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Yes Hospital or Attending Physician: 24 hours after death. Euneral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No ဂ္ Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined e Funeral I Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prantitioner 1. The best of my investigation of the council of the counci only one To the I within 2 date and place, and due to the cauce(b) and man 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 23 2012 D OO 327 30, Name and address of person who completed cause of death (Item 23a) (Type, Plint)

State Registrar HOSpite

s Signature

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		For State	State of	of Marylar				and M	lental Hy	/giene	9	0.000
		Registrar 1. Decedent's Name (First, Middle	Last)		Cer	tificate o	t Death		2. Date of De	Reg. No	. 201	2 2 3 8 0 3. Time of Death
Physiciar Medic		HArry Ro	IANZ	000	NI	11			Month	2	Year 20	
Examine	er	4a. Facility Name (if not institution, 1305 Gill Stre	et			Odent			1		nne Aru	ındel
Funeral Director		5. Social Security Number 212–29–6495 Usual Residence of Decedent	6. Sex 1 ፟፟ M 2 ☐ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Bir (Month, Da June	$\stackrel{\text{rth}}{1}\stackrel{\text{year}}{2},$	^{9. B} C 1987 Ma	irthplace (State or Foreign ountry) ryland
yland f show ed at	iot	10a. State 10b. County	1 . 1		ty, Town or Lo	cation						10d. Inside City Limits
r 28a- notifie	Director	Maryland Anne Anne Anne Anne Anne Anne Anne An	runaei	Va	enton	10f, Zip Cod	9			10- 0	itizen of What C	1 Ves 2 No
with the 23a cust be	Funeral	1305 Gill Stree	et			2111:				-	ted Sta	•
death items		11. Marital Status	Armed Fo	edent Ever in U.		Vas Decedent of Yes, specify C	of Hispanic Orig	in? (Spec	cify Yes or No- Rican, etc.)	- 1	14. Race - Am Black, Whi	
urs after tural", or al Exami	ted by	1 ☐XNever Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D		1	☐ Yes 2 🔀	No Specify:				Specify	hite
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		t's Education at grade completed College (1		(Give I	ent's Usual Occ ind of work dor ONOT use retin	ne during most	of workir	99		Cind of Business	
be filed w ental Hygi ked othel ic event, i	To Be	17. Father's Name (First, Middle, L Harry Roland Co	,						(First, Middle,	, Maiden	Surname)	
should and M is mai		19a. Informant's Name/Relationsh									r Town, State, Z	
and 2 Health em 27 ther tr		Harry R. Coon,	Jr. / Fa			Gill Si	t., 0de	nton	, Mar		d 21113	
age 1 ent of nt: If it y or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, cren	ematory	olace)	Ju1y 201	24 ,		ocation - City o	e, Maryland
permit. F Departm Importa any inju		21. Signature of Funeral Service L				-						D 21061
		23a. Part 1. Enter the disease, or shock, or heart failure. List o										Approximate Interval Between
Physician/ Medical Examiner	9	Immediate Cause (Final disease or condition resulting in death)	a. Due to	(offas a consequ	XIÀ uence of):							Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):							
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ath certificate be exe attending physician for use as the burial	ledical		d					-				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	come of pregna Birth 2 D Feta nant at time of a nown	al death 3	Ectopic pregn Other (specify)					23d. Date of do	elivery Day Year
ires that to signed by	d by	Part II. Other significant conditio	ns contributing to c	eath but not res	sulting in the u	nderlying cause	given in Part I.					to the cause of death? Probably 4 🔀 Unknown
a law requ	mplete								24a, Was auto			utopsy findings available completion of cause of
an: The tifficate or, pag	Be Co	25. Was case referred to medical	1			26.	Place of Death	Check	1 Yes	2 🔀 N		es 2 🗆 No
hysicia nis cer	9 P	examiner?	Hospital: 1 □	Inpatient 2 🗆	ER/Outpatien	10)ther:			dence 6	3 ☐ Other (Spe	cify)
iding Pl th. After tl funera		27. Manner of Death 1 Natural 5 Pendin 2 Accident Investic		of injury th, Day Year)	28b. Time of injury		juryat ork? □Yes 2 / Xt		8d. Describe h	now injur	y occurred	imself
To the Hospital or Attending Physician: The law requires that the der within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place	of Injury - At ho	ome, farm, stre			-	City or Toy	vn, State	d Number or Re	ural Route Number,
e Hospita 124 hours e Funeral	Medical	(Check 2 Medical E	Physician: To the becaminer: On the bas Nurse Practioner:	est of my know sis of examination	ledge, death o n and/or invest	gation, in my op	inion, death occ	curred at t	due to the ca	ause(s) ar and place	nd manner as st e, and due to the	tated. cause(s) and manner stated
To th within To th		29b. Signature and title of certifier	- A	200	eput		nse number		4		te signed (Moni	
5 m		30. Name and address of person v	/ho completed/cads	se of death (Item	23a) (Type, P	rint) 109	5 F	72	eri	CA	7 21	035
State Registra	~	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa		,	- #	, , ,			71	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	•	epartment of Health and	Mental Hygien	e 2012 23807				
			Registrar 1. Decedent's Name (First, Middle, Last		Certificate of Death	Reg. I	3. Time of Death				
	Physicia		JOON HAR	Chai			2 Year 7:15 AM				
	Medic Examin		4a. Facility Name (if not institution, give	/	4b, City, Town, or Location of Deat	h /	4c, County of Death				
**	-		SANDOLPH HILL 5. Social Security Number 6. Se	25 NURSING Hon 7. Age (In yrs. last birtho	ne Mheaton Dav) If Under 1 Year If Under 24 Hrs	8, Date of Birth	9. Birthplace (State or Foreign				
	Funeral Director		261-79-2728	M 2 XF 100 Y	Months Days Hours Min		Country) Check				
	ld st	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d, Inside City Limits				
	farylar 3a-fst tified	Director	MD HOOTER	1 1/	TOD		1 Yes 2 □ No				
	the N a or 28 be not	اق	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Country?				
	th with ms 23 must	Funeral	411 KANDOLPIA	12. Was Decedent Ever in U.S.	20906	nasifu Van au Na	USA				
9	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at		11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	14. Race - American Indian, Black, White, etc.				
21215-0036	urs aft tural", al Exa	Completed by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1 Yes 2 No Specify:		Specify: ASIAN				
15-	72 ho n "nat	mple	15. Decedent's Ed (Specify only highest gra	de completed) (Decedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired)	rking 16b.	Kind of Business Industry				
212	within giene. ner tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5+) + 2	Housewife		Domestic				
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	/	18. Mother's Na	me (First, Middle, Maide					
ary	should t and Me is mark raumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b.	Mailing Address (Street and Number or Ru	/ / / / / / / /	//// or Town, Ştate, Zip Çode)				
	and 2 sh Health a tem 27 is		HOON Jin CH	180 T80	09 Cliffs Edge CR	ti Louisville	2,KY 40241				
ore	ge 1 and stroft Hitch		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State cernetery	Disposition (Name of crematory or other place)	Date 20c.	Logation - City or Town, State				
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	1/_/(4.0	22. Name and Address of Facility	120412 11. F	UnexAL Hame				
<u>~</u>	permi Depar Impor any ir	-	Malo	Butto	10220 Gulfors	& Rd, See	SUD, 41) 20794				
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final		t enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death				
-	Medical		disease or condition resulting in death)	a. Due to (or is a consequence of	e Alzheimen's	alseAs	Se_				
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687	ertifica ding p se as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery				
Box 687	leath c e atten d for u	Physician/Me	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year				
P.O. E	t the d d by the stache	Phys	9 Unknown Part II. Other significant conditions co	9 Unknown	the underlying cause given in Part I	22a Did tahaan	o use contribute to the cause of death?				
s, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	d by	Tartii. Other significant contactions co	manbalang to dozur but not rooding an	the underlying eaded given in rate.		2 No 3 Probably 4 Unknown				
ord	w requ	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
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of V	g Physer this leral di	e: To	27. Manner of Death	1 Inpatient 2 ER/Out 28a. Date of injury (Month, Day, Year) 28b. Tir	me of 28c. Injury at	Home 5 Residence 28d. Describe how inj					
on	tendin eath. or: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No		***************************************				
Division of Vital Records,	lor At after c Direct		4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)				
	lospita 4 hours uneral ed fille	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ician: To the best of my knowledge, do	eath occured at the time, date and place,	and due to the cause(s)	and manner as stated. ce, and due to the cause(s) and manner stated.				
	the Fithin 24 the Foundation	Me			dge, death occurred at the time, date and place 29c. License number	ace, and due to the caus					
	F≥Fö		> Mank	legal mo	S						
	HM		allank Segal: MD D52261 7-23-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clank: Degal: 1517 Hugo Cincle, Silver Spring: 40 20906								
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signature	CLE, SINEN SPRIN	919020	966				
Ι.,	Registra		JUL 2 7 2012	men S. Sar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 9:45 Roger J. Colburn July A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days 215-68-0017 **Director** 1 X M 2 - F 56 October 11,1955 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director must be notified Harford Edgewood Maryland 1 Yes 2X No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 216 Redbud Road 21040 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, event, the Medical Examiner Black, White, etc ò þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Government 12 GIS Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked of

traumatic ever 2 George J. Colburn Gloria June Landis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Theresa C. Colburn/ Spouse 216 Redbud Road Edgewood, Md. 21040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral Chapel Bel Air 1 Burial 2 X Cremation 3 Removal from State 07/27/2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signatu Funeral Service Licensee Evans a funeral chapel Cremation Services-Belair 3Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between nset and Death Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No J Yes 2 N 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident 1 Yes 2 🗀 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, in w D 45-390 10 and address of person who completed cause of death (Item 23a) (Type, Print)

O Min (D.D.) 520 yran Chury Cake Drive # 409 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0 7 23/12° 10:43a M Donald E Campbell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 923 Blakistone Road Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Months Days Hours 04/01/1935 77 Ohio 279-32-5077 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Glen Burnie 1 🗌 Yes 2 🎇 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 923 Blakistone Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 XMarried Specify: White 1 Yes 2 No Specify: 1954-58 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Spray Painter General Motors 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Violet Johnson John Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Agnes M. Campbell Route 1 Box 73-B Belington WV 26250 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/25/12 Atlantic Crem Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Janeral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CARDIOM disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 5 Other (specify) a Unknown 23e. Did tobacco use contribute to the cause of death? CARDIOV ASCULAR 3 Probably 4 Unknown 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 2 No

Physician/ Medical **Examiner** Examine

Physician/

Medical

Examiner

10a, State

MD

Director

Funeral

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Completed

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Funeral

Director

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event.

Baltimore, Maryland 21215-0036

Iding physician and signed by the al d be detached for cate has been significant category can be category category.

Hospital or Attending Physician: The law requires that the death certificate be After this certificate

Division of Vital Records, P.O. Box 68760

within 24 hours after death. To the Funeral Director: Al completed filled in by the fu To the within 2 To the

Physician/Medical Completed by Be မြ Medical Certificate:

State

Registrar

g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BETES MELLITUS	24a. Was an autopsy performed? 1 Yes 2 No 124b. Were autopsy findings avail prior to completion of caus death? 1 Yes 2 No 1 Yes 2 No
26. Place of Death (Chec	ck only one)
al: 1	lome 5X Residence 6 Other (Specify)
Ba. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 1 Yes 2 No	28d. Describe how injury occurred
Be. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,

3 Suicide 6 Could not be 4 Homicide 6 determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation of the basis of examination and or investigation of the basis of examination of the basis of examination of the basis of examination of the basis of the basi	on, in my opinion, death occurred at	the time, date and place, and due to the cause(s) and manner state
29b. Signature and title of certifier MrD	29c. License number D 0059107	29d. Date signed (Month, Day, Year) 07 - 24 - 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CENTER DRIVE, REISTERSTOWN, MD 21136 UMA USINESS

31. Date filed (Month, Day, Year) JUL 27 2012

7. Manner of Death

Accident

5 Pending

Investigation

1 Natural

3 Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CLAYPOOLE 6:25PM ROBERT 20/2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAHARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 X M 2 □ F 212-30-8576 Usual Residence of Deceden 83 Oct 20, 1928 Maryland 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD **Baltimore** Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7711 Park 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: If Yes. Give Year or Dates. W White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Bowden Graphic Arts Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | is marked o ၉ George William Claypoole Sr Agnes Viola Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Marcia Lynn Fulton /Daughter 20 Packing House Rd. Hanover, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) Jul Beltsville, Maryland Chesapeake Crematori 2012 21. Signature of Funeral Service Lacensee 22. Name and Address of Facility Cremation and Funeral Alternatives MO1585 neimor 8717 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary embolus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an r this certificate has be eral director, page 2 st autopsy 2 🗌 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) July 24, 2012 D40Z7730. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 23a. pt. I d.per phy. g929 7-27-12 sm
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ George Edward Craven Sr. 4:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forest Hill Harford 325 Bynum Ridge Road Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month. Day, Year, Months 218-28-7519 **Director** 1**X** M 2 □ F Oct. 4, 1931 Maryland 80 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🎦 No Harford Maryland Forest Hill 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 325 Bynum Ridge Road 21050 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify "natural", 3 Widowed 4 Divorced White of Health and Mental Hygiene.

item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Gas & Electric Company Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Agnes Greer George Leigh Craven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 Bynum Ridge Road, Forest Hill, Maryland 21050 Barbara A. Craven 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of I Important: If ite any injury or other Burial 2 Cremation 3 Donation 5 Air Memorial Gdn 7-26-2012 Bel Air, Maryland ure of Fun 22. Name and Address of Facility McComas Funeral Home, P.A. 21. 3 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a co physician Division of Vital Records, P.O. Box 68760 use as attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by the at be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? after death. 1 \sum Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral E

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier-0014221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 76 MERRITT BLUD Suit 14 BALT MD 21222

State

Registrar

27

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pharles Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 070.40. Director 1 **X**M 2 □ F 7.2. NEW ork filed within 72 hours and tall Hygiene.
ed other than "natural", or items 23a or 28a-f show
es other, the Medical Examiner must be notified at. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director It's MORE 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygie If item 27 is marked other ir other traumatic event, ± Be 17. Father's Name (First, Middle, Last, ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placements) Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign o Funeral Service Licensee 23a. Part 1/Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ cancer uncurain nonths disease or condition resulting in death) metrismic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuquence of): Examir use as the burial-transi attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Hospital or Attending Physician: The law requires that the death signed by the at id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🚇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMES M 6701

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ Ronald Haythe Duffy 2012 8:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 226-78-8768 Director 1 🗙 M 2 🗆 F 60 6/4/1952 me 23a or 28a-f ehov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Cockeysville 1 🗌 Yes 2 🗷 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10303 Sunny lake Place Apt. 21030 Ι USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. 6 δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiena. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Disabled Disabled other treumatic event, 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clem Duffv Betty Lorraine Haythe 19a. Informant's Name/Relationship (Type, Print) 2012 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faith Donnerson-Sister 10303 Sunny Lake Place Apt.I Cockeysville.MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State parmit. Paga 1
Dapertment of
Importent: If It
eny injury or o 25, Burial 2 ☐ Cremation 3 ☐ Removal from State Organs Chapel Cem.7/31/2012 Gladys, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licenses March F/H- East 22. Name and Address of Facility 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: Tha law raquiras that the death cartificata ba executad within 24 hours after daath.

To the Funeral Director: After this cartificata has baen signed by the attanding physician and compliataly fillad in by tha funaral director, paga 2 should ba datached for usa as tha burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last RONALD DUFFY Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 88 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

TRACIE L. MORGAN.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's Signa

2300 DULANEY VALLEY RD.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TIMONIUM, MD 21093

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12:15P M Physician/ Daniel July 2012 Beverly J Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Examiner Glen Burnie 17 Clara Circle Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours Days Min. Marnth 1884, 1936 217-70-6475 Director Canada Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ıral", or items 23a or 28a-f s Examiner must be notified Glen Burnie Maryland Anne Arundel 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21060 Funeral 17 Clara Circle USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 72 hours after white 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Banking Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie Peachey Webster Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 Clara Circle Glen Burnie MD 21060 . Page 1 and 2 st ment of Health a tant: If item 27 is son Glenn Daniel 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc Baltimore Maryland 7/26/12 Funeral S 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signalure 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death Part 1. Enter the disease, or comshock, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the Immediate Cause (Final Phylician disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnag 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Month Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 1 No Hospital: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 23a) (Type, Print) 30. Name and address of pe son who completed cause 2106 Mua ma 0 Oba

Registrar

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of D Physician/ AGOO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1927 Norman Road Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 29 9. Birthplace (State or Foreign Funeral Min Director 215-24-7007 82 Nov. 1929 Maryland 1 M 2 L 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified to once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1927 Norman Road USA 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces' Black, White, etc. é 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) മ John Jackson Ines T, McCann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dragoo 1927 Norman Road Glen Burnie MD spouse 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/26/2012 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Funeral Se <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Orlset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Fitter Inderlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an death?
1 Yes 2 No 2 4 B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 HO Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending injury work? ☐ Accident☐ Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 Name and address of person who completed cause of death (Item 23a) (Type, Print) EVE 32. Registrar

PATIENT KNOWN AS "RD FORTSON"

			Please	Type or Print in BI				-	_	ible.	
			ForState	State of Maryland				Mental Hyg	giene		
			Registrar 1. Decedent's Name (First, Middle, Last	1	Cert	ificate of L	<i>Death</i>	2. Date of Dea	Reg. No. 2	0 12	2 23816
	Physicia Medic		R.D. F	ortson		· · -		Month JULY	Day	Year 2012	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give s SINAL HOSPITAL				Location of Death		4c. County	of Death	/A
San James I	Funeral		5. Social Security Number 6. Sec			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth			place (State or Foreign
	Director		257 - 28 - 6818 1 E Usual Residence of Decedent	M2□F 96	ZYrs.	Months	Hours Will.	(Month, Day) July 1.	5, 1920	Coun	5-A
	yland f sho	tor	10a. State 10b. County		Town or Loca	1 .		,		1	10d. Inside City Limits
	or 28a	Director	10e. Street and Number		Dai	10f. Zip Code	<u>a</u> _		10g. Citizen of V	Mhat Cour	yes 2 □ No
	filed within 72 hours after death with the Manyland al Hygiene. d other than "natural", or items 23a or 28a-f sho dent, the Medical Examiner must be notified at	Funeral	3404 Mar	mon Ave	2		1207		rog. Onizerror	43	A
	r item		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	
99	rs after ral", o Exam	ed by	3 Widowed 4 □ Divorced	1 √es 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 🖼 No	Specify:		Specify:	BI	ack
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$\overline{\sigma}$	c se p	To Be	17. Father's Name (First, Middle, Last)	ink			18. Mother's Nam				
lary	should and Me is marl raumati		19a. Informant's Name/Relationship (Type			1 6 4	and Number or Rur	-			` _
e, N	and 2 Health tem 27 ther tr		Audrey Monr 20a. Method of Disposition		340L	HMQrn ition (Name of	non Au	L, 50	20c. Location -	_	
mor	bage 1 ent of nt: If it ry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State . cem		atory or other place	e) 7	27/2012		timo	
3alti	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Sign ture F eral Service Dicens		22.	Name and Addres	ss of Facility	owel	L Fu	ner	ral Home
	405 40	Н	23a. Part 1. Enter the disease, or comp	fications that caused the death.	Do not enter	the mode of dyin	g, such as cardiac	or respiratory arm	MS HI	بو, ا	Approximate
	hysician/		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		·	NFARCT			ķ	Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequen	ice of):					\neg	
		-	Sequentially list conditions,	b. ATHEROSCLE		C HEAR	T DISEAS	٤		-	30 YEARS
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
	e executed cian and ourial-transit	l= I	resulting in death) Last	Due to (or as a consequen	ice of):						
760	icate b physic sthe t	ledic		d						\pm	
Box 68760	h certif tending or use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy		Ectopic pregnand	cy .			te of deliv	*
. Bo	he deat y the at iched fo	Physician/Medica	1 Yes 2 No 9 Unknown	4 Pregnant at time of dea	ath 5□	Other (specify)			Mo	onth	Day Year
Division of Vital Records, P.O.	To the Hospitallor Attending Physician: The law requires that the death certificate be within £4 hours: efer death. Within £4 hours: efer death. To the Luneral Director After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	by	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the un	nderlying cause giv	ven in Part I.				he cause of death?
ords	been s should	Completed	THORETON					24a. Was a		, .	psy findings available
Sec.	sician: The law r certificate has b lirector, page 2 s	omo						autop perfor	sy med?	prior to co death?	ompletion of cause of
tal	cian: T	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Chec		2,24,6]		
ž	Physi rthis o eral dir	은	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 X Inpatient 2 ☐ EF	R/Outpatient Bb. Time of	3 DOA Other	4 ☐ Nursing H	ome 5 Resid			v)
ouo	ending seth. rr Afte he fun	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work		200. 200050	on mjury essuar	34	
ivisi	To the Hospitallor Attending Physician: The la within 24 hours "fer death. To the Funeral Lirector After this certificate ha completely filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
۵	ospital hours uneral	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examin	ician: To the best of my knowled- ner: On the basis of examination ar	ge, death o	ccurred at the time	e, date and place, a	and due to the ca	use(s) and man	ner as stat	ted.
	the H thin 24 the F	Me		e Practitioner: To the best of my		death occurred at t	he time, date and p	lace, and due to the	ne cause(s) and r	nanner as	stated.
			RO. O. 10	MD		RES -	9 number 1992065 1		29d. Date signed		*
U	J Km		30. Name and address of person who co	ompleted cause of death (Item 23		rint)					
	Sta	_	BRANDON COAK 31. Date filed (Month, Day, Year)	LEY, MD		AI HOSP	ITAL OF	SALTIM	ORE		
	Registra		JUL 27 2012 De	32. Registrar's Signature	المحا		<u>-</u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2:45 P. M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty Ann Franz-DeHaven July 2²3° 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford County 4b. City, Town, or Location of Death **Examiner** Edgewood 1721 Dearwood Court Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 M 2 X F 218-72-3559 52 0177877960 Texas Director Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 No Maryland Harford County Edgewood 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Completed by Funeral 1721 Dearwood Court 21040 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 1 XYes 2 □ No Specify: Panamanian 3 Divorced Specify: Hispanic Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Paulina Gonzalez ပ Bruno Franz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other tratonce. 607 Country Club Rd., Apt. E., Red Lion, PA 17356 Krystal DeHaven (Daughter-In-Law) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \nearrow Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place) 07/30/2012 Forest Hill, Maryland Evans Funeral Chapel 22. Name and Address of Facility vans Funeral Chapel & Cremetion Services Bel Air Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between et and Death Immediate Cause (Final Fragacian/ Dreas eals disease or condition Medical resulting in death) Due to (or as a conse ue ce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on Exami been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? cate has page 2 s eral Director: After this certificate filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ဂ္ 1 🗌 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completed filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier -012

State Registrar

DHMH 17 Rev 7/2009

A. park

510 Upper Chesapeake

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Bahrani

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Elaine Diane Fox 12:50 PM 6 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 10-24-1958 Months Director 53 216-78-9115 Washington. Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d, Inside City Limits or 28a-f sh notified a MD Montgomery Olney 1 XYes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be ed other than "natural", or items 23a event, the Medical Examiner must b Funeral 4213 Stafford Road 20832 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 💢 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ျှ Marvin Herbert Fox Harriet Kurland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Alan Fox - Brother 4213 Stafford Road, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Cemetery 7-1-2012 Falls Church, Virginia . Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Brad Smetzer Bu 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Respiratory Failure Medical resulting in death) **Examiner** Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cellulitis and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 \(\subseteq \) Yes 2 \(\bar{\text{N}} \) No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Acute Renal Failure, Diabetes, HTN, CHF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2X No death? certificate 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X** No မ 1 X Inpatient 2 [ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 🗌 Yes ieral Director: A filled in by the fi 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064502 7-23-2012

Registrar

DHMH 17 Rev 7/2009

State

- 9901 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registra 's Signature

Brian Carpenter,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ de 3:00 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 59 **Director** 1 M 2 1 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland FORDHYDE Funeral Director Examiner must be notified 1 Yes 2 No timore 10e. Street and Nur 10f. Zip Code items 23a or 10g. Citizen of What Country? 21229 USA ountwood Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Yes 2 No þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 MILDRED If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ₩idowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO Not use retind) 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other trainment. condary (0-12) College (1-4 or 5+) Be ne (First, Middle, 18. Mother's Name (First, Middle, မ Poute Number, City or Town, 28144 20a. Method of Disposition Place of Disposition 1 Burial 2 Cremation 3 Removal from State Patient 4 Donation 5 Other (Specify) ure of Fune al Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ 30 days disease or condition Medical resulting in death) s a consequence of): **Examiner** Stage Renal Disease 4ears Sequentially list conditions, if any a congrete immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year Pregnant at time of death the the Unknown 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I autopsy performed? Yes 2 No death? After this certificate funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending of 24 hours after death the Funeral Director. A pletely filled in by the f 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.B.B.S PAS-18240 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 Simon Hospital EDEM W.Belvedere 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of D Physician/ 27°, Gourrier Miriam Edna July 2012° 1:14a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Towson Gilchrist 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Nov. 17,1916 Months Hours Min. Louisiana Director 437-54-6892 1 M 2 X F 95 Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at 10a, State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Acworth Cobb Georgia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 30102 5203 Centennial Hill Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: B1ack al Hygiene. Specify: 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Public School Teacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Importent: If item 27 is marked othe any injury or other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname)
May Lillian 17. Father's Name (First, Middle, Last) မ Porche С, Ricard George 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Assunta Gourrier-Jäckson Acworth, GA 30102 5203 Centennial Hill Drive timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. New Orleans, LA Vincent 2 Aug. 10,201 21. Signature of Funeral Service License ^{22. Name and Address of Facility} Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 HArford Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ li ca disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death

1 Natural
2 Accident
3 Suicide To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only or 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of cert 29c. License number

DHMH 17 Rev 06-2011

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) reeu

06

Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Julia Lee Griffin JÜĽŸ 24 ay 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-90-6806 **Director** 1 M 2 X F 46 11/20/1965 Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location Director must be notified Baltimore Maryland 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral 1320 W.Lexington Street 2nd FL. 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. q 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Unemployed 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Leroy Griffin Sandra Diggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimika Gholson/daughter 1001 N.Gay Street Apt.204 Baltimore MD.21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 08/01/12 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD. New Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral le 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Providian peritonitis D to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially liet condition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cell carcinoma metastatic quamous Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ρţ in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate Yes 2 To the Hospital or Attending Physician; funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 욘 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of Certificate: (Month, Day, Year) 1 Natural 5 Pending work within 24 hours after death

To the Funeral Director, A

completely filled in by the f 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Interval Between Onset and Death

one week

Year

Day

1 🗌 Yes 2 🗆 No

Month

1X Yes 2 □ No

Maryland

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DHMH 17 Rev 06-2011

State Registrar

6503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gottlieb Month Physician/ 2012 \mathbf{P}^M 2:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Potomac Valley Nursing If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 578-54-3837 1 M 2 X F 72 8-1-1939 Unknown er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral with 20910 United States 8600 16th Street, #703 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Yes 2 No 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Unknown Specify: White 3 Widowed 4 Divorced Year or Dates. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hyglene. within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown Unknown Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event 2018. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Bess (Unknown) William Gottlieb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 77 S. Washington St., #304, Rockville, Maryland Bernadette Sweeney- LAWYER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Olney, Maryland Judean Gardens 7-27-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service /Brian Deibler 1091 Rockville Pike, Rockville, Maryland 20852 Juan للمد 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Skin Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 HUnknown Completed 24b. Were autopsy findings available 24a, Was an page 5 autopsy performed? Yes 2 No has prior to completion of cause of 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Certificate: 1 Accident (Month, Day, Year) 5 Pending death. 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the i Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-26-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registra 's Signature

Marichu Matas, MD - 1235 Potomac Valley Road, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Second Part	10a. State 10b. County 10c. City, Town or Location 10d. Inside	1D
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	The second of th	
	The second of th	manner stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
Dr.Patrick Turnes, 114 Business Center Drive, Reisterstown, MD 21136	Dr.Patrick Turnes, 114 Business Center Drive, Reisterstown, MD 21136	
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature Authority Signature	

Carl ANTHONY 12-05306 Garlick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day July 14, 2012 Carl Anthony Garlick 1958 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 218 South Fulton Street Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 09/14/1963 Country) MD 48 1 M 2 F UNR Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State E A 10b. County 10c. City, Town or Location VA 1 Yes 2 X No Gladys 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien and Department of Health and Mental Hygien from Empartment of Health and Mental Hygien Empartment of Health and Mental Hygien 123a nr 28a-f she injury nr other traumatic event, the Medical Examiner must be notified at once injury nr other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5252 Covered Bridge Road 24554 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes 2X No White 1 Yes 2X No specify: 4 Divorced If Yes, Give Year 3 Widowed Specify **À** 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore**, MD 21215-0036 Construction Roofer 12yrs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ralph Garlick Lois Trout Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5252 Covered Bridge Road Gladys VA 24554 Beth L. Garlick Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 7/21/12 Glen Burnie MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licens ThomasAllenPA 7090 Ridge RD Hanover MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Madical Death a Narcotic (morphine) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical g physician a the burial -MENDED 23a, 27, 28a-f, per me, g930 8-1-12 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Fetal death e attending p for use as th Day Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been a il director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 🗹 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: n 24 hours after death.

The Funeral Director: A sletely filled in by the fu Natural 1 Yes 2 x No 5 Pending fd 7-14-12 | fd 6:00 pm Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 218 South Fulton St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be (Specify) found in vacant house Baltimore, MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 15, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, 2. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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		Physici Medi		1. Decedent's Name (First, Middle, Last Thomas Hopki	ns							2. Date of De Month	_	Pay - 1). Year		ne of Death
		Exami	ner	4a. Facility Name (if not institution, give Joseph Ritchi		.	*	4b. City	, Town, or Balt	Location o	of Death		4	Ic. County of De	ath	
		Funeral Director		5. Social Security Number 216-74-6912 6. S	ex 7. Age	(In yrs. la	ast birthday) Yrs.	If Unde Months	Days	If Under Hours		8. Date of Bit 1/4/5	rth ay, Year,	9. B	irthplace (St ountry) MD	ate or Foreign
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A .	. Box 6876(To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use es the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Feta	aldeath 3 🗌	Ectopic Other (s		EY .				23d. Date of d Month	elivery Day	Year
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	Division of Vital Records,	ending P sath. or: After ti	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		Year)	28b. Time of injury	м	28c. Injury work 1 □	∕at ? Yes 2□		d. Describe	how inju	ury occurred		
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_		To withit to a district the congression of the con		29b. Signature and title of certifier	1				c. License		1.0			ate signed (Mon)
		39		30. Name and address of person who	completed cause of dea	ath (Item	23a) (Type, P	rint) ,	H(O	10649	HO 1			1-25	17	
1		Sta	te	31. Date filed (Month, Day, Year)	HMFGMMA 32. Registrar	's Signat	ture	indl	1 th	bal	th HO	2130				
		Registr		JUL 2 7 2012	Brown 1	1.	perce	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician. Month Day Veal 2023 M Medical 2012 4a. Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death HOPKINS HOSPita lohns **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 218-42-4691 1 □ M 2 🕱 F 68 January 21,1944 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits notified Harford Maryland 1 Yes 2 X No Joppa 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe items 23a oner must be Funeral 21085 2309 Reckord Road United States "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Armed Force 1 Never Married 2 🔀 Married Black, White, etc. ò Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hair Dresser 12 Beautician Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or မ William Reiter Catherine Newberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold K. Hudson/spouse 2309 Record Rd. Joppa, Md. 21085 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ò X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Department o Important: If any injury or Highview Memorial Maryland 4 ☐ Donation 5 ☐ Other (Specify) 07/27/2012 Funeral Service Licenses 21. Signatur 22. Name and Address of Facility 3 Newport Drive Forest Hill Md. Evans Funeral Chapel & Cremation Services-Bellir 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BOWEL Physician/ ECADSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month 2 🗸 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury neral Director: A Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number SCHWANTZ

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

0

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

UWANTZ

1800 N. Orleans St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / 35 are near 930 the and Mersell Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20^{Day} Physician/ JULY 20 1º2 11:42P M MARY H. HARPER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours 230-74-8200 1 □ M 2 🔀 F Director VIRGINIA Yrs July 24,1953 58 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at PRINCE GEORGE'S 1 X Yes 2 No CLINTON 這 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? e filed within 72 hours after death with the tal Hygiene.
ed other than "natural", or items 23a or event, the Medical Examiner must be I Funeral 20735 USA 6215 GATOR PLACE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceden. Armed Forces?
1 ☐ Yes 2 ▼ No 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Patent Trade FEDERAL GOVERNMENT and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SELMA LABOARD NATHANIEL WOODARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. MELVIN HARPER/HUSBAND 6215 GATOR PLACE CLINTON, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 07/30/12 CLINTON, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, 7474 LANDOVER RD HYATTSVILLE, MD 20785 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Onset and Death Immediate Caus se (Final Physician/ disease or condition resulting in death) Medical **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury AROVED BY MEDICAL EX that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy __ Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital. Other: ျ 1 XYes 2 ER/Outpatient 3 DOA 1 Nnpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 2 No 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 29d. Date signed (Month. Day, Year) ne and address of person who completed cause of peath (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend #5, per INF, g930 8-2-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ :50 PM leer forver 2012 0 YNN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Huspita usedale Baltimore Square If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Min. Months Hours Month, Day Year) 69 Maryland 1942 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 ¥ Yes 2 ☐ No Baltimore 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral United States 21206 5922 Belle Vista Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Menones. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rose Marie Lepka Warner Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy Horner /Daughter 5922 Belle Vista Ave. Baltimore, MD 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Jul 28 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2012 461585 Signature of Funeral Service License 22. Nai Ozema trison Familia Funeral Alternatives ۵ 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiomyo Physician/ schemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Stenosis Hospital or Attending Physician: The law requires that the death certificate be executed 10Y that initiated events resulting in death) Last as the burial-tran the attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year tate has been signed by the atte page 2 should be detached for Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No iniury 1 Matural 5 Pending death. Investigation ☐ Accident hours after death uneral Director: / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопріете (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D73722 July 26, 2012

Registrar

DHMH 17 Rev 7/2009

State

guare Drive

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ertman

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 Month 25^{ay} 20 ft2 4:45P M Barbara Mary Hobday Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death
Carroll Examiner Westminster Carroll Hospital Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔼 F Months Days Hours Min 10/28/ 217-38-5355 73 NY Director Usual Residence of Decedent or 28a-f show notified at ·1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
firem 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Finksburg 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21048 2036 Shreeveley Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Library Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Brown Edgar G. Fenrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 03470280 S.Scofield Mountain Rd., Winchester, NH Andrew Fenrich-brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 7/26/12 Winfield 4 Donation 5 Other (Specify) 21. Ignatu Aug neral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21157 254 Ε. Main St. Westminster, MD . Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. 1. Ente Immediate Cause (Final disease or condition Onset and Death Physician/ teres Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine erebrovasch signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 No Yes Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 110 Certificate: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasts of examination and/or investigation, in this opinion, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat Name and address of person who completed cause of death (Item 23a) (Type, Print) lending duty, Mentanius 149 12 21150

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a&23PIT G930 8/17/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ FRANK E. HEMBERGER, JR. TIIT.Y 2012 4:10A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE BALTO. TOWSON

If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min 93 Director 167-10-8029 1 M 2 □ F PENNSYLVANIA Vrc JULY 28,1918 r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location Director 1 X Yes 2 No BALTIMORE MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21206 4904 WILLSHIRE AVENUE 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☑ No
If Yes, Give
Year or Dates. 1943—1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: WHITE 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) 12TH College (1-4 or 5+) MACHINIST MARTINS Be 17. Father's Name (First, Middle, Last) th and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည SOPHIA STEIN FRANK E. HEMBERGER.SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 BALTIMORE, MD. 21206 5917 CEDONIA AVENUE SON FRANK HEMBERGER III Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-26-2012 TIMONIUM, MD. DULANEY VALLEY 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21. Signature of Funeral Service BALTO. MD. 21206 6415 BELAIR ROAD Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest phock, or heart failure. List only one cause on each line. Part 1. Enter the disease Approximate Interval Between Onset and Death **PNUEMONIA** Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the attending physician and the for use as the burial-transit Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time = IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 2 □ Mo cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate Division of Vital funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 🗌 Yes 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner at ath Certificate: 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Director: After (Month, Day, Natural 5 Pending 1 ☐ Yes 2 ☐ No death the Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct filled in by determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, deterand place, and due to the ause and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

2 7 2012

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

com MD

			Pleas	se Type or Pr						•		-) .
			For State Registrar	State of N	/laryland /		artment of <i>tificate of</i>			,	giene Reg. No	201	2 2383
П	Physicia	an/	1. Decedent's Name (First, Middle, L							Date of Dea	ath Da	ay Year	3. Time of Death
meg	Medi	cal	ADOLPH ISIDO 4a. Facility Name (if not institution, g		FFMAN		4. 67. 7			TULY	16	201.	2 1549 PM
	Examir	ner	ST AGNES	HOSPI	TAL		4b. City, Town, BAL	TIM			40	c. County of Dea	ath
	Funeral	Г	, , ,		ge (In yrs. last b	irthday)	If Under 1 Yea Months Days		er 24 Hrs. 8. Min.	Date of Birl		g. B	irthplace (State or Foreign ountry)
	Director		119-16-3375 Usual Residence of Decedent	1 XM 2 □ F	87	Yrs.				06/07			NY
	/land f shov ed at	tor	10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits
	e Man r 28a- notifie	Direc	MD HOWA	RD	C	OLUM							1 Yes 2 No
	2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Funeral Director	10e. Street and Number	LIAV			10f. Zip Code				10g. Ci	itizen of What C	Country?
	leath v	Fune	6225 WILD SWAN 11. Marital Status	12. Was Decedent		13. V	as Decedent of	1045 Hispanic O	rigin? (Specify	Yes or No-	Т	USA 14. Race - Am	erican Indian,
36	hours after death natural", or items lical Examiner mu	þ	1 Never Married 2 Married	Armed Forces			Yes, specify Cul			an, etc.)		Black, Whi	
5-0036	hours latura ical E	letec	3 Widowed 4 Divorced	Year or Dates.	16	ia. Deced	ent's Usual Occi	nation			16h k	(ind of Business	WHITE
21	ifiled within 72 hour tal Hygiene, od other than "nature event, the Medical	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4 or		(Give k	ind of work done NOT use retired	during mo	st of working		100.1	and of business	5/ Mudstry
121	d within Hygiene. ther than nt, the M	Be C	12 17. Father's Name (First, Middle, Las	41		QUA	LITY COL						OF DEFENSE
Maryland		To E	BERNARD	i)	HOF.	FMAN			her's Name <i>(Fi</i> CRTHA	rst, Middle,	Maiden	,	ACOBWITZ
ary	should and M is mar		19a, Informant's Name/Relationship	(Type, Print)			g Address (Stree	1		ute Numbe	r, City oi		
	1 and 2 should be if Health and Men item 27 is marke other traumatic		MARGOT HOFFMAN	/WIFE		6225	WILD SW	IAN WA	Y, COL	UMBIA	, MI	21045	5
Baltimore,	e = to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		e cemet	tery, crem	sition (Name of atory or other pla	1	Date		20c. L	ocation - City o	r Town, State
ltin	permit. Pag Departmen Important any injury		4 Donation 5 Other (Spe		ARLI	_	NATION Name and Addr		08/03/			T. MYE	R, VA S., INC.
Be	permir Depar Impor any ir		1	EL		- 1	900 REIS						-
	Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lir	ne.		r the mode of dy			spiratory arr	rest,		Approximate Interval Between Onset and Death UNKNOWN
	Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							UNKNOWN
	1	Jer	DUODENAL SMALL BOWEL BLEED If any, leading to immediate Due to (or as a consequence of):							2	UNKNOWN		
of	ecuted and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. COAG ULOPATHY									I DAY.	
Bo	e exec cian ar urial-t		resulting in death) Last	Due to (or as	a consequence	e of):				_			
68760	cate be ex physician s the buria	edic		d		-							
89	eath certifica attending p	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy		Ectopic pregnar					23d. Date of de	elivery
Box	Hospital or Attending Physician: The law requires that the death certificate be explanters after death certificate be explantered after death certificate has been signed by the attending physician trely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		Other (specify)	ncy				Month	Day Year
P.O.	that the dea ned by the a detached is	y Ph	Part II. Other significant conditions							23e. Did to	bacco (use contribute t	o the cause of death?
ds,	v requires that been signed be should be det	ted t	TRANSFUSI	ON RELA	ITED /	ACUT	E LUNG	G IN	UJURY	1 🗆 ነ	Yes 2	□ No 3 □ F	Probably 4 Unknown
of Vital Records,	has be ge 2 sho	Completed by								24a. Was a	SV	prior to	utopsy findings available completion of cause of
Re	sician: The lar certificate ha irector, page?									1 Yes	rmed?		es 2 No
/ita	ystciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0 [] 50/6	N	Ot	hor:	ath (Check oni				
of/	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of inju	tient 2 ER/C ury 28b.	Time of injury	28c. Inju	ry at		5 L Resid		Other (Spe y occurred	cify)
ion	uttendin death. ctor: Af y the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not	on	iy, rear)	injury	M 1	Yes 2	No		_		
Division	pital or Attencours after deatheral Director: ,	Cert	4 Homicide determine	28e. Place of Inj	jury - At home, f tc. (Specify)	arm, stre	et, factory, office		28f.	Location (S City or Tow			ural Route Number,
	Hospital or At 24 hours after o Funeral Direct etely filled in by	Medical	29a. Certifier 1 Certifying Pt	nysician: To the best of	f my knowledge	, death or	ocurred at the time	ne, date an	d place, and d	ue to the ca	iuse(s) a	nd manner as s	stated. cause(s) and manner stated
	To the Hosp within 24 hor To the Fune completely f		only one) 3 Certifying No	urse Practitioner: To the	ne best of my kno	owledge,	death occurred at	the time, d	ate and place,	and due to the	he cause	e(s) and manner	as stated.
	F		M. Sündl	uja j	1D		29c. Licens	24i	133			te signed (Mont	
	3		30. Name and address of person who	COMPLETED CAUSE OF COMPUDIT,	death (Item 23a)	(Type, Pr	int)	E, B	ALTIM	IORE	, M	D 2	1229.

DHMH 17 Rev 06-2011

State Registrar SINDHUJA

31. Date filed (Month, Day, Year)

AVE, BALTIMORE, MD 21229.

12-05485 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Joel Robert Hooper State of Maryland / Department of Health and Mental Hygiene 2012 23832 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 22, 2012 0708 hrs **Medical Examiner** Joel Robert Hooper 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death 1604 Governors Bridge Road Anne Arundel Davidsonville 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Hours Months Davs Director 219-84-5371 10/21/1967 Country) 1X M 2 F 44 Yrs Usual Residence of Deceden 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Annapolis . Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiene, and train and treat and Montal Hygiene are in the free 37 is marked after than "natural", ar items 33s or 28s-f sho man the traumaite event; the Medical Examiner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 332 Charred Oak Court 21409 TISA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes If Yes, Give Year 1 Yes 2 X No specify: White 4 Divorced Specify á 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) James E. Hooper, Anita King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Jeffrey A. Hooper, Jr (nephew) 251 Carroll Rd., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) Burial 2 Cremation 3 Removal from State Department o Metro Crematory, Inc. July 25,2012 Baltimore, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other Scene this 1 Yes 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self Natural FOUND: 1 Yes 2 ✔ No Pending the within 24 hours after death Tn the Funeral Director: Jul 22, 2012 0701 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1604 Governors Bridge Road, Davidsonville, MD determined (Specify) Field Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 22, 2012 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2072 12:50 P_M Kenneth Elwood Hawks Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Apt 311 20 Hammarlee Road Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 1 □**X**M 2 □ F Director 229-14-3800 Virginia Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director must be notified 1 Yes 2 No MD Anne Arundel Glen Burnie ö 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country? 23a Funeral 20 Hammarlee Road Apt. 311 21060 USA items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No "natural", or q Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☑ No Specify: white Completed Specify: 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meones. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ L. Clarion Hawks Josie \mathbf{E} Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene J Walker daughter 8324 Dock Road Pasadena MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placement) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oakland United Methodist 7/28/12 Galax Virginia 22. Name and Address of Facility Stallings Funeral Home P.A. Signature Funeral Service Mountain Road Pasadena MD 21122 23a. Parts. Enter the disease, or complications that caused if shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician -ERY D15 279 87-CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death the g Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page certificate 1 Yes 2 No Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🗓 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Acciden Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 163632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 808 LANDMANL DR. T. E 128, GLON BURNE KUMAH

DHMH 17 Rev 7/2009

Registrar

			Please	Type or Prin	t in B	lack Ind	lelible Ini	k. Ensure	All Copie	s Are	Legible	
		For		State of Ma	ryland				Mental Hy	/giene	201	2 23831
		1 - State Registrar				Certi	ficate of L	Death		Reg. No.	201	2 23031
Physic	ian/	Decedent's Name Sharon		st) Jacobs					2. Date of Do	eath Day	y Year	3. Time of Death
Med Exam	dical	4a. Facility Name (if r				anter a	h City Town o	r Location of Deat	12014	74	County of Dea	
Exam	liner	0 11.	arely	ushinoitas	M.	recter?	B. City, lowil, of		Sins		4006	ath a land
Funera		5. Social Security Nu	imber 6. S	ex 7. Age	(In yrs. las		f Under 1 Year Ionths Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth	9. Bi	rthplace (State or Foreign
Directo	r	214-52-90 Usual Residence o		□M2\\ F (62	Yrs.	lonuis Days	Hours Willi	(Month, D			ountry) MD
and show	٥	10a. State	10b. County		10c. City,	Town or Locati	ion					10d. Inside City Limits
Maryla 28a-f	rect	MD	Anne Ar	undel	M	lillers	ville					1 ☐ Yes 2 🔀 No
h the	a Di	10e. Street and Num		- "- 1			10f. Zip Code			10g. Citi	izen of What C	ountry?
IIG Z1Z13-UU30 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the <u>Medical Examiner must be notifiled at</u>	Funeral Director		r Wheel	Lane #14			21108				USA	
or iter	by Fr	11. Marital Status 1 ☐ Never Marrie	ed 2 🗆 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🕅 N	er in U.S.	13. Was	s Decedent of H es, specify Cuba	ispanic Origin? (S in, Mexican, Puer	pecify Yes or No to Rican, etc.)	•	 Race - Am Black, Whi 	
3-UUSO 2 hours after "natural", o	ed b	3 X Widowed 4		If Yes, Give Year or Dates.	io .	1 🗆	Yes 2 X No	Specify:			Specify: wh	ite
2 hou "natu	Completed	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)	- 1		t's Usual Occup	ation during most of wo	rkina	16b. Ki	nd of Business	s/Industry
thin 7	۱ĕ	Elementary/Secon		College (1-4 or 5+)	life. DO N	IOT use retired) keeping	•	g	Mar	nagemen	t Property
Hygir Hygir other ent, t	Be (17. Father's Name (F	irst, Middle, Last)				Recping		me (First, Middle	Maiden S	Surname)	
Tan Je fi fental rked tic ev	ြု	Raymond	Gerald W	illiford				Hattie	Josephi		Fuka	
Dal ILITIOTE, INITIVITIEN 2 1 2 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Nar						and Number or Ru				ip Code)
e, ry and 2 s Health tem 27				bs III/son				Glen Bu	rnie MD	2106	1	
in ite		20a. Method of Dispe 1 🔲 Burial 2 🗵	Cremation 3	Removal from State	cen	ce of Disposition	orv or other plac	ce) 7/2	Date 8/2012	1	ocation - City o	
Datumor permit. Page 1 Department of Important: If it any injury or c	a l	4 ☐ Donation 21. Signature of Fun	5 Other (Special		Meti	o Crem						
Demit Depar Impor			A A	1//	1364	421	Crain	Hwy SE G	rkley-R	uddic	k Fune	ral Home
		23a. Part 1. Enter the	e disease, of com	plications that caused to the cause on each line.	he death.	Do not enter th	ne mode of dyin	g, such as cardia	or respiratory a	rrest,	D 21001	Approximate
Physician	7	Immediate Cause (F	inal		SEP	55					63	Interval Between Onset and Death
Medica Examine	_	resulting in death)	C	Due to (or as a								
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ted Insit	Examiner	if any, leading to immore cause. Enter Under Cause (Disease or in	ying njury	Due to (or as a c		160 01): 164.~0.	NIA				- 24	
e executed cian and ourial-transit	EX	that initiated events resulting in death) L		Due to (or as a								
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Attending Physician: The law requires that the death certificate be ar death. The control of th	Physician/Medic	IF FEMALE:		23c. If yes, outcome of	· orognono							
attendation of for us	cian	23b. Was decedent p in the past 12 m 1 Pes 2	nophis?	1 Live Birth 2	Fetal o	death 3 🔲 Eo	ctopic pregnanc ther (specify)	;y		2	23d. Date of de Month	elivery Day Year
that the deaned by the a	hysi	9 Unknown	INO	9 Unknown								
is that igned to be det	by P	Part II. Other signific	cant conditions c	ontributing to death but	not result	ting in the unde	erlying cause giv	ven in Part I.	23e. Did 1	tobacco us	se contribute to	the cause of death?
require been sig									1 🗆	Yes 2	□No 3□F	Probably 4 Onknown
law re has be le 2 sh	ompleted		_	 -					24a. Was auto	psy	prior to	topsy findings available completion of cause of
an ner ian: The la rtificate ha	O	25.11								ormed? 2 No	death? 1 ☐ Ye	s 2 1 No
ysiciar ysiciar is certif directo	Be	25. Was case referred examiner? 1 Yes 2		Hospital:			Oth	ace of Death (Che er:				
a Phy er this	<u>اة</u>	27. Manner Death		28a. Date of injury	28	R/Outpatient 3 8b. Time of	3 L.J DOA 28c. Injury	4 ☐ Nursing F	lome 5 Resi 28d. Describe			cify)
ending eath. or: After	licat	1 Natural 2 Accident	5 Pending Investigation		Year)	injury	M 1 □	? Yes 2 ☐ No		, , ,		
or Atter de free de lirector in by t	Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	28e. Place of Injury building, etc.		e, farm, street,	factory, office		28f. Location (City or Tox		Number or Ru	ıral Route Number,
pital o		29a. Certifier 1	ACCURATE ONLY	- To the board of					1	·		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Medical	(Check 21	Medical Exami	sician: To the best of m iner: On the basis of exa se Practitioner: To the b	mination a	ınd/or investigat	tion, in my opinic	n. death occurred	at the time date:	and place	and due to the	cause(s) and manner stated
Vithin To the Comp	2	29b. Signature and ti		C Tractitioner: to the L	Deat of Triy	Knowledge, dea	29c. License		place, and due to		s) and manner a e signed (Mont	
ک		•	20	ele			D.	00537	03	Ju	Ly &	14/2012
12		30. Name and address	ss of person who o	completed cause of dea	th (Item 23	3a) (Type, Print	ca	00537 Cerr7	-n			
	ate	31. Date filed (Month,	, Day, Year)	32. Registrar's					,, <u> </u>			
Regist		JUL 27		Burns A	6	2. 1. 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** acobs 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oldspring more 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) . Age (In yrs. last birthday) Security Number **Funeral** 1 M 2 □ F Days So with Months Hours Yrs. 247-56-76/3 Usual Residence of Deceden Carolina Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner πust be notified at 1 Pres 2 No Director 10g. Citizen of What Country? 10e. Street and Number 22 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) provement Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lacubs 2 19a. Informant's Name/Relationship (Type. Print) (Son) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Mb 21223 Salto, Mb 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING 5 Other (Specify) Funeral Service Licenses Home, P.A. 21. Signature of Avc. W. North Approximate Interval Between Onset and Death 23a. Part. Enter the disea at or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia **Physician** Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 1 Yes 2 No certificate the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA £ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D0069314 MD

State Registrar

DHMH 17 Rev 1/2001

Walthym

Wood

Rd Parkville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8813

32. Registrar's Signature

Praj

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 23836 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUV PATRICIA A. JOHNSON 3:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 579-96-2592 Director 1 🗆 M 2 🔀 Yrs. 48 FEB. 16, 1964 WASHINGTON, DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director PRINCE GEORGE'S 1 X Yes 2 □ No MD BOWIE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or Funeral 15728 EAST HAVEN CT 20716 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 X Never Married 2 Married ō þ 2 **X** No ☐ Yes 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify: BLACK 'natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) INVENTORY MGMNT SPECIALIST FEDERAL GOVERNMENT Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ JOE R. JOHNSON PATSY HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JOE R. JOHNSON/FATHER other t 8019 ALLENDALE DR PALMER PARK, MD 20785 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/2012 Landover, Maryland 4 Donation 5 Other (Specify) Harmony 22. Name and Address of Facility J.B.JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee N 7474 LANDOVER RD HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final TASTRIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** TASTASI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death the a 9 Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 NO မ 1 Yes 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director; After Natural 5 Pending iniury ours after death. eral Director: Aft filled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print)

7500 Hangver Parkway Suite IOIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar 238**3**7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2012 8:00 P M Ida Kolker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery <u>Hebrew Home of Greater Washington</u> Rockville If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🗓 F Months Days Hours Min Oct. 18, New York 95 $^{'}1916$ Director 058-03-3359 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at anoe. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Montgomery 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20852 6121 Montrose Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: If Yes, Give White Completed 3 X Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) G.E.C.C. 4 Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chawkins Chawkins Sarah Samue1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 Grosvenor Pl., Rockville, MD Andrew Kolker / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 07/24/2012 Beltsville, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician/ disease or condition resulting in death) Medical ORGANISMS **Examiner** Sequentially liet non-fittons Examine if any, leading to immediate cause. Enter Underlying physician and s the burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death No s been signed by the s should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, 2 210 Hospital: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director; / Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title of certifie anus D

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 215-82-0332 1 □ M 2 🛛 F 05/28/1960 MD ifiled within 72 nous and tall Hygiene.

ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 🗌 Yes 2 🗓 No BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? Funeral 4600 ALCOTT WAY, #403 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces 1 Never Married 2 Married ☐ Yes 2 🖾 No δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) MASTER BARBER COSMETOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Heelth end Mental H item 27 is marked o ပ္ RUTH MALTZ treumatic STUART BLUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD BLUM/BROTHER 27 GLYNDON DRIVE, #A-2, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportent: if its eny injury or ot once. Pege 1 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 07/26/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Certificate: To Be

To the Hospital or Attending Physicien: The law requires thet the deeth certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 4

				1 Yes 2 No 3 Probably 4 Unknown						
				24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No						
25. Was case referred to medical			26. Place of Death (Che	ck only one)						
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I	pital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other Specify p								
27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 Suicide 6 Could not l			ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a Certifier 1 Certifying Phy	sician: To the best of my know	ledge death occurred	at the time, date and place.	and due to the cause(s) and manner as stated.						

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a

2012

31. Date filed (Month, Day, Year) State 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departme		Mental Hyg		10 0000
			Registrar Certifica 1. Decedent's Name (First, Middle, Last)	te of Death			12 2383
	Physici Medi		Cynthia Earl Kerman		2. Date of Dea Month July	22 ^{Day} 201	3. Time of Death 3:25 A M
	Exami	ner		y, Town, or Location of Death		4c. County of D	
H	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	er 1 Year If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
		1	Usual Residence of Decedent		July I6	, 1923	India
	laryland a-f sh o ified at	Director	MD Baltimore Glen Arm				10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	a or 28 be not			ip Code		10g. Citizen of What	
	ath with	Funeral		1057		USA	
36	ifter des ", or ite aminer		1 ☐ Never Married 2 ☐ Married Armed Forces? If Yes, spe	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto l 2 🕅 No Specify:	ecity Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
-00	hours a natural lical Ex	leted	Year or Dates. 15. Decedent's Education 16a Decedent's Use				hite
Maryland 21215-0036	thin 72 ane. than "ı ne Med	Completed by	(Give kind of wo life. DO NOT us	ork done during most of worki e retired)		16b. Kind of Busine	
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ylan	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	은	Edwin Charles Magarey Earl	Barbara T		,	
Mar	12 shou lith and 27 is n r traum			s (Street and Number or Rural ntainberry Cir			
Baltimore,	e 1 and of Hea If item or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	me of		20c. Location - City	
<u>ă</u>	it. Pagi irtment irtant: injury o		4 Donafor 5 Other (Specify) Hilltop Servi	ce Corp 7/25/	²⁰¹²	Towson, M	
Ba	Depar Impor any ir			owson Funeral	Home, In		York Road on, MD 21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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	Examiner	-e	Sequentially list conditions, b.				
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,	icate be executed g physician and s the burial-transit	al Ex	that initiated events resulting in death) Last Due to (or as a consequence of):				
3/60	certificate b nding physi use as the b	l edical	d				
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Э	the dea by the a ached f	hysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (sc 9 Unknown	ecify)		Month	Day Year
7.	es that signed I I be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.		1	to the cause of death?
Vital Records,	w requir	oletec	Ristrictive lung disease		1 ☐ Yes		Probably 4 Unknown
Lec Lec	ate has	Com			autopsy perform 1 \sum Yes 2	prior to ned?/ death?	completion of cause of
. 5	sician: certific irector,	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ID No Hospital:	26. Place of Death Check of Other:	only one)		
5	ng Phy ter this neral d	te: To	27. Manyer of Death 28a. Date of injury 28b. Time of 2	DA 4 Mursing Hom 8c. Injury at 28	ne 5 Residen 8d. Describe how	nce 6 Other (Spe vinjury occurred	ecify)
VISION OF	ttendil death. stor: Af / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	work? 1 Yes 2 No			
	ral or A		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	office 28	8f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
1	to the fospital of Attaching Physician. The law requires that the death with 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occurred at	ny oninion death occurred at the	he time data and	place and due to the	acusada) and mannas stated
ļ.	Vithin To the compl	— г	only one) 3 - Certifying Nurse Practioner: To the best of my knowledge, death occur	red at the time, date and place,	, and due to the ca	ause(s) and manner a	s stated.
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mexits Day Year)	D 204 33		July 24,	2012
	/q	Ì	M H Charles and address of person who completed cause of death (Item 23a) (Type, Print)	Street Ba	Winner	e Mi	21204
	State Registra	<i>•</i>	11. Date filed (Moth Day Fear) 32. Registra's Signature 32. Registra's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, per MD 9929 7/27/12 trt
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 931 PM UALTER LYNCH. 07 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN BAUTIMORE HOSPITAZ Baltimore City 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Hours Director 215-56-0054 1 № M 2 🗆 F MD. 63 Aug. 16,1948 Yrs. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director Baltimore County 1 Yes 2 X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 701 Elmwood Rd. 21206 USA items ? permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? þ ¥ X Never Married 2 ☐ Married 1 Yes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs Clerk District Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary T. Burnotes Jeremiah J. Lynch, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 North Beaumont Ave. Catonsville, Md. 21228 Mary Lynch (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 7-16-12 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home 21. Sign re of Funeral Service Licensee HOW 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PHEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner LUNG CANCER - NON SMALL CELL 14EAR Sequentially list conditions, in any, leaving to immediate cause. Enter Underlying Examine Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant : 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CAD 1 Nes 2 No 3 Probably 4 Unknown COPO 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural injury 5 Pending Accident Investigation s after deatl 6 Could not be Suicide within 24 hours after des

To the Funeral Director

completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 MO July 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORI-AMN FISHER 21239 RANGON BLVID State JUL 2 Registrar

		AM.	END PII,	25,27,28	e Type or SA-F, PE	Print in	Black	Indeli 24/12 partme	ble Inl	k. Ens	ure A	II Copie: lental Hyd	s Are	e Legib	ole.		
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	Funeral Director		01000 1010	M 2 □ F	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Pay, Year		thplace (State or Foreign untry)
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36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	वि	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
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Maryland	2 should be file lith and Mental I 27 is marked or r traumatic eve		19a. Informant's Name/Relationship (Type)	Print) 19b. I	Mailing Address (Street &	and Number or Rura	ELIZAE I Route Number, City Ven Buer	or Town, State, Zip	071612 0 Code) 21060
Baltimore,	. 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		Disposition (Name of crematory or other place	per 7/20		Location - City or	
Balti	permit. Page Department Important: I any injury o		21. Signature of Flueral Servin Linense		22. Name and Address	SUIFORA	HOWELL RA JES	FUREAR	20794
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. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnanc 5 Other (specify)	у		23d. Date of de Month	olivery Day Year
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Division	To the Hospital or Attending Phys within Evalurs after death. To the Funeral Director: After this completed filled in by the funeral di	Il Certificate:	3 Sulcide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Street City or Town, Sta		iral Route Number,
	he Hospii in 24 hou the Funeri pleted fill	Medical	(Check 2 Medical Examine	ian: To the best of my knowledge, der: On the basis of examination and/or Practioner: To the best of my knowle	investigation, in my opinio	on, death occurred a	the time, date and pla	ice, and due to the	cause(s) and manner stated.
		ł	29b. Signature and title of certifier	latas	29c. License			Date signed (Mont)	h, Day, Year)
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	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Synature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Steven Ledley 2012 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Court Assisted Living Kensington Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 082-22-1682 1 X M 2 □ F 86 Yrs. 6-28-1926 New York permit. Page 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other then "neture!", or Items 23e or 28e-f ahrean injury or other freumetic event, the Medical Experience. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George Laure1 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17000 Melbourne Drive 20707 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Rlack. White, etc. δ 1 Never Married 2 X Married 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Professor Science 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Levy Kate Finkelstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17000 Melbourne Dr., Terry Ledley - Wife Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 7-26-2012 Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Brad Smetzer Bund 1170 Rockville, Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani Hypertensive Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): The law requires that the deeth certificete be executed been signed by the ettending physicien end should be deteched for use es the burlai-trensi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year g Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes__2\ldot No Hospital or Attending Physicien: The 24 hours effer death. Funerel Director: After this certificate if 1 Yes 2 No ☐ Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 4□Nursing Home 5□Residence 6\ other Specify 1 ☐ Yes 2 🗓 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours e Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0064024 7-24-2012

DHMH 17 Rev 06-2011

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

Janna Lachthinina,

27 2012

4301 Knowles Ave., Kensington, Maryland 20895

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LEONARD E. LEHMAN ,JR. **2322 HRS**[™] TULY 23. 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UPPER CHESAPEAKE BEL If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Hours 214-50-4913 1 **X**M 2 □ F Director MAY 29,1949 MARYLAND 63 Usual Residence of Dec 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD HARFORD **JOPPA** 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral must 1603 EVA AVENUE 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Examiner Black, White, etc. P þ 1 Never Married 2 Married 1 Yes If Yes, Giv 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. WHITE "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the AUTOMOBILE INDUSTRY LINE WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic eve ျှ LEONARD E. LEHMAN SR. ALICE V. NEISSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORA E. DIETZ SISTER 4260 CHAPEL ROAD PERRY HALL, MD. 21128 20a. Method of Disposition
1 □ Burial 2 ♣ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 7-26-2012 GLEN BURNIE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Rath. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical 68760 as ed by the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown signed by t. Id be detach P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page perform certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospita 1 Yes 2 No ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural injury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 h To the Fur Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Ce ifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 500 Upperchesapeak

DHMH 17 Rev 06-2011

Registrar

Leonard

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5/10/600 V

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 24,2012 12:20A.M DIAMONTO EVELYN LAMBROS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTO. TOWSON GILCHRIST Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Country) Director 219-10-2464 102 1 □ M 2**X** F CONNECTICUT 1-10-1910 th and Mental Hygiene. 27 is merked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 I No BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4307 SPRINGWOOD AVENUE 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X 72 hours after Maryland 21215-0036 al Hygiene. WHITE 1 Yes 2 No Specify. Specify. 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **ASSEMBLER** WESTERN ELECTRIC 8TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CONSTANTINOS TOURNAS NASTASTA KAMPERI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any Injury or other treu DTR 412 LYMAN AVENUE BALTIMORE, MD. 21212 CONSTANCE HOUSTON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State BALTIMORE, MD. GREEK ORTHODOX CEM. 7-27-2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, BALTO. MD. 6415 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0011 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam anding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ettending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Tyes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 A Other (Specify 100) PLC 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t the Hospital or Attending I thin 24 hours after death. the Funerel Director: After 1 Natural 2 Accident 5 Pending injury ours after death. lerel Director: Af filled in by the fu 1 Tyes 2 🗆 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu e and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST AALONI M) 31. Date filed (Month, JUL 2 32. Registrar's Agnature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day PM Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) birthday) **Funeral** Months Davs Hours 1 M 2 F Director 42 Yrs. 70 10b. County 10c. City, Town or Location State the Maryland at **Funeral Director** notified 1 ☐ Yes 2 ☑ No ASADEMA ANNEARUNDE 28a-MD 10f. Zip Code 10g. Citizen of What Country? 20 10e Street and Number pe ms 23a c must be 1122 permit. Page 1 and 2 should be filed within 72 hours after death with .S.A Z 225 GLEN items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 0 þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates "natural", MITE Completed 3 Widowed 4 Divorced ?7 is marked other than "natural tranmatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry YOTOR VEHICLE life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Z Be Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ BEAVER THEODORE W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEOLORE BEAVER GLENNCT 225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-20-12 MENTON. Signat 2601 MOUNTAIN RD. PAGATENA Part 1. Enter the disease, shock, or heart failure. Lis caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or compl Interval Between Onset and Death Immediate Cause (Final Due (or as a consequence of): Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 1 🗌 Yes 25. Was case referred 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 2 🗆 No Inpatient 2 - ER/Outpatient 3 - DOA within 24 hours after death.

To the Funeral Director: After this Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending iniury 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

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31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item

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For State		of Maryland / Dep	artment of H rtificate of D			0.0	112	2381
	r s Name (First, Middle, Last)		tillcate of D	caui	2. Date of De	Reg. No. /	116	3. Time of Death
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	ame (if not institution, give street and not SAMAPITAN)		4b. City, Town, or I	ocation of Death	, mD	4c. County		
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Mar Mark 19a. Informal	nt's Name/Relationship (Type, Print)	. 1	ng Address (Street ar			-		ode)
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Division of To the Hospital or Attending P within 24 hours affect death. To the Hospital or Attending P within 24 hours affect death. To the Funeral Director. Affect completely filled in by the funeral place of the following properties of the following	2 Medical Examiner: On the b	e best of my knowledge, death pasis of examination and/or invester: To the best of my knowledge	stigation, in my opinior	, death occurred	at the time, date a	and place, and du-	e to the cau	se(s) and manner stated
29b. Signatur	and title of certifier	am	29c. License		>	29d. Date signer	1 2	lay, Year)
30. Name and S A M	d address of person who completed ca	5601		LAVEN	U BL	LUD, BI	ALTIY	norE
State 31. Date filed Registrar	(Month, Day, Year) 32.	Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 21, Frances L. Myers ^{Day} 2012 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooklyn Park Anne Arundel 26 Rene Ave. 8. Date of Birth (Month, Day, Yea Aug . 10, Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 □ M 2 🙀 F Hours 1940 Maryland Director 213-36-3651 71 Usual Residence of Decedent 28a-f show Director 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified Brooklyn Park Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21225 26 Rene Ave. United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces "natural", or Completed by 1 Never Married 2 Married 2 🛛 No Baltimore, Maryland 21215-0036 ☐ Yes 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Medical Care Billing Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Garnet Francis Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau once. 1205 Crain Hwy., N, Apt. A, Glen Burnie, MD 21061 Brenda A. Resuta / Daughter 20a. Method of Disposition July 25, 2012 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State cemetery, crematory or other place) onation 5 Other (Specify) Crematory, Catonsville, Maryland Inc 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., 21. Signat Funeral Home, P.A. S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ptund disease or condition month Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and burial-trar Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 X No ed by the a g Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performed certificate 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospital Other: မ 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 🔀 Natural 5 Pending injury s after death.

I Director: Aft
ed in by the fur 2 Accident
3 Suicide
4 Homicide Investigation М 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D filled Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) July 23, 2012 0518/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) homas 1/20 410121 filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2²4ay 2012 Edith R. Meyers 0635 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours 293-14-6732 1 □ M 2X F 89 12-13-1922 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Kensington Montgomery 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3500 Kensington Ct. 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education 5+ Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Robbins Emma Rosenthal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3303 Tidewater Ct., #C-19, Olney, Maryland 20832 Pamela Gorin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 7-25-2012 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens Olney, Maryland 21. Signature of Funeral Service Licensee Brad Smetzer 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852

permit, Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me Once. Physicians Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show e notified at

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2 should be filed within 72 hours and working the and Mental Hygiene.
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Baltimore, Maryland 21215-0036

ed by ti page 2 s n 24 hours after death.

Funeral Director; Ai bletely filled in by the fu

only one) 29b. Signature and title of dertiffe

31. Date filed (Month, Day, Year)

JUL 2 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

certificate

After

	shock, or heart failure. List only one Immediate Cause (Final		or respiratory arrest,		Approximate Interval Between Onset and Death
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Ž	resulting in death) Last	Due to (or as a consequence of):			
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ly Steriary men	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregnancy 1		23d. Date of de Month	livery Day Year
ed by r i	Part II. Other significant conditions conf	cributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
oldilloo			24a. Was an autopsy performed? 1 □ Yes 2 ▼	prior to death?	topsy findings available completion of cause of
	25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)		
2	1 ☐ Yes 2 ☐XNo	ospital: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗀 Nursing Ho	ome 5 🗆 Residence	6 Other (Spec	eify)
lcare.	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Stat		ral Route Number,
Medico	(Check 2 Medical Examine	ian: To the best of my knowledge, death occurred at the time, date and place, a r: On the basis of examination and/or investigation, in my opinion, death occurred at Practitioner: To the best of my knowledge, death occurred at the time, date and pla	t the time, date and place	e, and due to the	cause(s) and manner stated

29c. License number

D65953

29d. Date signed (Month, Day, Year) 7-24-2012

DHMH 17 Rev 06-2011

State Registrar Jonathan Duran, MD - 1500 Forest Glen Road, Silver Spring, Maryland

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 56 pm Physician/ JOHN C. MULLANEY, SR. 2012 JULY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death HARFORD **Examiner** JOPPATOWN 403 AVERY CT 8. Date of Birth (Month, Day, Year)
NOV 20,1936 If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 - F 75 Director 218-30-0760 MDUsual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director JOPPATOWN HARFORD 1 ☐ Yes 2 No notified MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 403 AVERY CT ò Examiner must be 20185 Funeral items 23a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Types 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: WHITE Specify: Completed 3 ¥ Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) MASS TRANSIT ADMIN BUS DRIVER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ETHEL SMITH ည THOMAS MULLANEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number City of Town State, Zip Code) 2204 SHETLAND WAY BEL AIR, BRENDA ZULAUF-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State HIGHVIEW CEMETERY FALLSTON, MD 7/28/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR ignature of Funeral Service BEL AIR, MD 21014 610 W. MACPHAIL RD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cinama montas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗆 Yes 2 M No 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: iniury 5 Pending ✓ Natural 2 🗌 No 2 Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of the best of the knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar only one)

29b. Signature and title of certifier

CARL S. FRIEDMAN, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

515 FAIRMONT AVE, TOWSON, MD 21286

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Grace Oliver hilv 5:35 p.^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days (Month, Day, Year) **Director** 219-16-6652 1 □ M 2 🛣 F 87 7-7-1925 MD Usual Residence of Decedent filed within 72 hours arm. ... tai Hygiene than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 21208 6 Stockmill Road, Apt G 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify African-American Completed 3 Midowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Kitchen Manager Deimas House 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ပ Ann M. White John White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i 9511 Meadows Farm Drive, Owings Mills, MD 21117 Theresa Oglesby/ Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Garrison Forest Veterans : 7-31-2012 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signawre of Funeral Service 22. Name and Address of Facility Willie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final uestovasular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) cate has been signed to page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Amies

32. Registrar's Signature

31. Date filed (Month, Day, Year)

ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ Month Day 01:13A M Sidney Phillips JULY . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** August 2. 055-14-7685 Director 1 X M 2 | F 91 Yrs. Massachusetts 1920 Usual Residence of Decedent or 28a-f show 0a State **New** 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Melville Suffolk 1 Yes 2 No York 10e. Street and Numbe 10f. Zip Code TO ATTENDED TO THE STATES 23a Funeral 11747 21 Deerfield Lane of America or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify: white "natural", Specify: 3 Widowed 4 Divorced Baltimore, Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Professional Engineer Engineering 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental F. 7 is mark မ Esther Phillips Louis Phillips 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15927 York Road Sparks, Maryland 21152 19a. Informant's Name/Relationship (Type, Print) Department of Heath and I st. Important; If item 27 is 1 any injury or other traumones. Bradley L. Phillips/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 26, Evans Funeral Chapel-Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature F heral Service Line Penceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Urosepsis 1 da disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Karkinson's disease 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 1 Yes 2 No Yes 2 -25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After t 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20043489 20 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Brian School 6585 N, Charles SJ. 52, 550 Bohra 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ Pearl Elizabeth Price 2012 21 5:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 1 □ M 2 🛣 F 579-56-3953 83 Aug. 5, 1928 Maryland Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Lanham 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 5814 Lawton Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 √ Widowed 4 □ Divorced Completed **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumosin. Elementary/Secondary (0-12) College (1-4 or 5+) Government House Keeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dozie E. Harley Robert L. Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5814 Lawton Court Lanham, MD 20706 Brenda A. Ware/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 07/30/2012 Clinton, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Licensee N. Naphney 7474 Landover Rd Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SITOCIC Physician/ JEP TIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner AILUR ESPIRATURT Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Exami physician and s the burial-transit 14821L ひられるしてて or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Aft
y filled in by the fur 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0044957 WO 2012 2 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause d

DHMH 17 Rev 06-2011

Registrar

Paul Wagner

Randall

Ave Unit 1500 Takoma Park, MD 20912

7600 Canroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland				1ental Hy	giene	201	2 2	385
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	eath	2. Date of De	Reg. No.	201		
	ysicia Medic		Genevieve J. Paul				Month 07	1 9 Day	2012		of Death
	xamin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or l			1	ounty of Deat		
F			302 L Canterbury Rd. 5. Social Security Number 6. Sex 7. Age (In yrs. last l	hirthday)	Be 1	Air If Under 24 Hrs.	8. Date of Bir		Harfor	thplace (State	or Foreign
	neral ector		219-22-7649 1□M2⊠F 83	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	MD	untry)	e or r oreign
pu pu	at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loc	cation		03/01/	1,20		10 d . Inside	City Limits
Aaryla 8a-f s	tified	Director	MD Harford Bel	L Air						1 □ Y	es 2 🛣 No
the N	pe no	i Di	10e. Street and Number		10f. Zip Code	-		10g. Citize	n of What Co	ountry?	
th with	must	Funeral	302 L Canterbury Rd.		21014			USA			
or iter	niner		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	13. W	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto I	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, White		
036 rs afte	Exan	ed b	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Sp	ecify:	White	
5-0 2 hour	adical	plet	15. Decedent's Education 1 (Specify only highest grade completed)	6a. Deced	ent's Usual Occupation	tion Iring most of working	na	16b. Kind	of Business/	'In d ustry	
21215-0036 within 72 hours after death with the Maryland gine.	he Me	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DC	NOT use retired) Housewife			Hot	memake	r	
Maryland 2121 2 should be filed within 7 th and Mental Hygiene. 77 is marked other than	ent, t	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,				
/land de formal	atic ev	욘	Nicholas Insogna			Mary	Cimagl	ia			
Maryland 2 should be filed ith and Mental Hy 27 is marked oth	anma				g Address (Street ar						
and 2 s Health	ther t				Boston St						+
Baltimore, bermit. Page 1 and Department of Heam	important. Intent 2.1 is marked outer than inquiral, on neurs 259 of 259-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ceme	etery, crem	natory or other place)	Date 7 1 2 1 2		tion - City or		
Baltimo permit. Page Department of	injur		21. Signature of Funeral Service Licensee		Forest Ce				imore, ral Ho		
m Fer	any in		Defauie Kunkis		610 W. Ma						
Exam	dical niner	iner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause That Hood, and Cause (Disease or injury) Due to (or as a consequence cause).		nyelon	~				Interval B Onset and	
Box 68760 death certificate be executed ne attending physician and	the buri	/Medical Examine	that initiated events resulting in death) Last C. Due to (or as a consequence d								
). Box (the death ce y the attency	be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)			230	d. Date of del Month	livery Day	Year
Records, P.O. The law requires that the ate has been signed by the	oe d	ру	Part II. Other significant conditions contributing to death but not resulting	g in the ur	n d erlying cause give	n in Part I.	23e. Di d t			the cause of	
of Vital Records, ng Physician: The law requires ter this certificate has been sig	page 2	Completed					1 🗆 Yes		24b. Were authorito of death? 1 Yes	topsy finding completion of	s available f cause of
ision of Vital Attending Physician: Pr death. ector: After this certific	director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outnotion	Other	ce of Death (Check 4 Nursing Hor			041/0	*£.1	_
of V g Phys er this	neral		27. Manner of Death 28a. Date of injury 28b	o. Time of injury	28c. Injury		28d. Describe h			пу)	
on o ending l eath. or: After	the fur	fical	2 Accident Investigation	irijui y	M 1 ☐ Y	es 2 🗆 No					
.≥ કહ્યું હૈ	in by 1	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	2	28f. Location (S City or Tov		umber or Rui	ral Route Nur	nber,
Hospit 4 hour Funer	tely filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	d/or investi	gation, in my opinion	, death occurred at	the time, date a	and place, an	d due to the o	cause(s) and r	nanner stated
To the within 2	Сощ	2	29b. Signature and title of cyriffier	go,	29c. License r		_ 5, 6.76 660 10 1		igned (Month		_
50	$M \sim$		30. Name and address of person who completed cause of death (Item 23a JENKATA PARSA 570 U	PPER	e CHESI	PEAKE	DR	BEZ	AIR I	ADZ	1014
Re	Stat gistra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	whit	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2017 nara pmero 2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death HOPKINS Johns Himore Funeral Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 7.46,9861 Director 1 - M 2 X F YORK 28a-f show 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** items 23a or 28a-f s ler must be notified 1 Yes 2 No PRINCE WILLIAM VIRGINIA WOOPGRIDGE 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 2197 UNITED STATES 12256 SEAFORD COURT 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or ite Completed by 1 Never Married 2 Married Yes : 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than ' event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 10 ACCOUNTANT ALLIANT TECH SUSTEMS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 of Health and Ments fitem 27 is marked rother traumatic e THEODORE PANZIER WHITFIELD DOROTHEA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROMERO - HUSBAND SANTOS COURT SEAFORD JODDORITHE, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 ; = 5 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or 4 Donation 5 Other (Specify) જ NATONALCEMETER TRIANGILE, VA Signature of Funeral Service Licenses 22. Name and Address of Facility MILEE FLAREAL HONE JANSKY BLUD, WOODBRIDGE, VAZZI9Z 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner auchtfally list sonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 00 thy that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial Completed by Physician/Medical Box 68760 signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral Manner of Death Certificate: 28b. Time of 28c. Injury at Hospital or Attending 1 Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No death. Accident within 24 hours after deatl To the Funeral Director. 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Baltimore MD, 21287

State Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

1212MGA

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18, per fh, g929 7-27-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Koberts 9:12 AM riane July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore $\mathcal N$ university of maryland medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Hours -549 1 □ M 2 🔀 F **Director** ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Yes 2 No altimble 10e. Street and Number 10g. Citizen of What Country? F/007 Completed by Funeral 21202 1 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Health nnicia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Page 1 and 2 should I ment of Health and Me City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural_Route Number, am Department of Health Important: If item 27 WE other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or altimore, 4 ☐ Donation 5 ☐ Other (Specify) UY 21. Signature of uneral Service Licensee 22. Name and Address of Facility any hm Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Anoxic Provincian/ coin days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Day Year ed by the a 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗍 Probably 4 🕶 Unknown ate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Sease 24a, Was an certificate has autopsy performe 2 No 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗌 No 1 Natural injury 5 Pending n 24 hours after death.

le Funeral Director: A pletely filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 1740489970 person who completed cause of death (Item 23a) (Type, Print) 30 Name and address maryland 2/201 22 South Greene Street, Baltimores CRN Hagan, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Robertson 1032 PM J Month 2012 Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore VA Medica Baltimore If Under 1 Year If Under 24 Hrs. Social Security Numbe 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 046-44-8278 0370471950 CT62 **Director** 1 XM 2 □ F 28a-f show 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No Cecil MD Perryville 10e. Street and Number 10g. Citizen of What Country? 0 er than "natural", or items 23a of the Medical Examiner must be Funeral 515 Broad Street 21903 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 White rr Yes, Give Year or Dates. 1968-70 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unk Unk 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Donald Robertson Liza Tencer Robertson 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Duncan Robertson 1308 Hickman Road Augusta GA 30904 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Atlantic Crem 1 Burial 2 XCremation 3 Removal from State 7/24/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser Signature of Funeral Service Lice ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et alk that s Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner MEMMORIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last ears Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 N 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) 1 Yes 2 No Hospital ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending iniury work?
1 Yes 2 No 24 hours after death. Funeral Director; Af Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1093081515 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MD 21201 10 N Greene St.

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 235 2012 Marilyn Corrine Reichert 8:03A Medical 4a. Facility Name (if not institution, give street and number) 4b. Cîty, Town, or Location of Death Examiner 4c. County of Death Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 215-48-4282 Director 1 | M 2 | F 01/14/1946 66 MD 2 should be filed within 72 hours efter death with the Meryland ith and Mental Hygjene.
27 is merked other than "neturel", or items 23e or 28e-f ehow treumatic event, the Medical Evenment must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Niner's Private Road 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces 1 Never Married 2 Married δ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Richard Niner Mary Madeline Bixler .. Pege 1 end 2 should b tment of Heelth and Me tant: If Item 27 is merk jury or other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Bryson-daughter 300 Niner's Pvt. Road, Westminster, Md., 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pege 1 Depertment of important: if it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Deer Park 7/28/12 Smallwood, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E. Main St., Westminster, Md., 21157 21. Signature of Fundami Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pheart failure. List only one cause of the c Immediate Cause (Final Onset and Death Priysician disease or condition Medical resulting in death) Due o or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of). ettending physicien end I for use es the burial-trensit Exami The lew requires that the deeth cartificete be executad Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death sete hes been elgned by that pege 2 ehould be deteched 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of autopsy death? certificete 2 - No 2 1 No 1 🗌 Yes or Attanding Physicien: funerel director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specific 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours efter death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie To the Hosp within 24 hor To the Fune completely fi (Check 3 Certifying Nurs Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifie Month, Day, Year 29d. Dâte signe

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23859 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ein 11:13A TU Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4300 COTTINGTON ROAD **NOTTINGHAM** BALTO. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 F Days Months Hours MARCH 9 Year 941 220-36-4822 MARYLAND Director 71 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other terms. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x No MD. BALTO. NOTTINGHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 COTTINGTON ROAD 21236 USA Was Deceden.
Armed Forces?
Yes 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify WHITE If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMIN. ASSISTANT JOHNS HOPKINS UNIV. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည ELMER I HARRER ANNA D DEVINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES REINTZELL **SPOUSE** 4300 COTTINGTON ROAD NOTTINGHAM, MD. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 7-28-2012 BALTO.MD. 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Signat e o Funeral Service Licensee 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter or respiratory arrest shock, or heart failure. List only one cause on each Interval Between set and Deal Immediate Cause (Final 0 Physician/ disease or condition Medical resulting in death) Due to (or as a cor Examiner ease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo 5 Other (specify) Month Day Year Pregnant at time of death Yes signed by the Unknown Unknown opt regulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performe After this certificate 2 No Yes 25. Was case referred to examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 \(\text{Yes} မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 1 Watural 5 Pending injury 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation the Funeral Dire. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 ho

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completed fi (Check only one 29b. Signat 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of berson who completed cause of death (Item 23a) (Type, Print) 10

State Registrar 32. Registrar Signa

ORKRD

12-05546 Charles Rybczynski Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland	/ Department of He	ealth and N	√lental Hygiene

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		1- For State Certificate of Death Registrar		g. No.	2 2000	
Physicia	ın/	1. Decedent's Name (First, Middle,Last) Charles Robert Rybczynski	2. Date of Death Month July 24, 20		3. Time of Death 1930 hrs	
Medical Examii		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat		
		2230 McKendree Road West Friendship		Howard		
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	_	h(MM/DD/YYYY) 9. Bi Forei		
Director	-	216-94-9301 1X m 2 F 48 Yrs. Months Days Hours Min.	July 13	1, 1964 ^c	Maryland	
b		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
iow any		MD. Howard West Friendship			1 Yes 2 No	
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	entry?	
th the Maryland 23a or 28a-f sho notified at once	D is	2230 McKendree Road 21794		USA	A	
with ms 23	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1. Whomas Marital Status) 14. Was Decedent of Hispanic Origin? (Sp. 1. Was Decedent of Hispanic Origin? Puerto		14. Race - Ame White, etc.	rican Indian, Black,	
r deatl	Funeral	1 Yes 2 X No	,	Specify: W	nite	
us afte	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	vork done	16b. Kind of Business		
5-0036 led within 72 hours r Hygiene. other than "naturr the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire	red)			
vithin ene.	ם	4 School Teacher		Education		
filed v Hyging of other true	ပိ	17. Father's Name (First, Middle, Last) C. Edmund Rybczynski Anita	,	raiden Surname)		
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	The street and Number 10e. Street and Number 2230 McKendree Road 11. Marital Status 1 Meyer Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Student of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race White Table 1 Mexical Status 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do Not use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Authority of Working Info Do Not use retired) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow 106 Carrbridge Rd. East Stewartston 1 Mexican Surname Authority or other place) 19a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. 7-27-12 Towson				e, Zip Code)	
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Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traur		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	r Town, State	
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Balti permit. Departm Imports injury o		21. Signature of Juneral Tervice Consete 22. Name and Address of Facility FU	meral H	ome, Inc.		
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval				
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Upper Gastrointestinal Hemorrhage Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	<u>-</u>	Sequentially list conditions, b. Bleeding Esophageal Varices Due to (or as a consequence of the conditions)				
,	Ë	cause. Enter Underlying Cause (Dispass or injury that initiated) c. Hepatitis C Infection with Cirrhosis of the Liver				
ansit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
760, crate be executed physician and the burial - transit	Medical Examine	UNPENDED AMENDED				
760, cate be physici the buri		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delive		
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Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown				
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Cospita fospita t hours funera		4 Homicide 29a. Certifier 1 Certifying Physician: To the heat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated				
o the Fithin 2, o the Formplete	27. Manner of Death 1				he cause(s)	
F 3 F 8	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)	
	1	fill O.C.M.E.		July 25, 2012		
G_{l}		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	nore, MD 212	223		
\ St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature				
Regist	rar		OCARE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2 2 ay 20^{Year} Lakisha Denise Smothers 11:35pм Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Upper Chesapeake Medical Center Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Min Director 195-54-9077 1 □ M 2 🕱 F 08/05/1975 Pennsylvania Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10h County 10c City Town or Location 10a. State Director notified Harford Maryland Abingdon 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 0 must be i 23a 21009 3216 Trellis Lane USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Was Deceden. _ Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. ō by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural" 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Own Home Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 12th grade other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r is marked of Carol Denise Akens Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. B216 Trellis Lane Abingdon,Maryland 21009 Joseph Smothers Sr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State St.James Cemetery 07/30/2012 Havre De Grace MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityChatman-Harris Funeral Home 4210 Belair Road Baltimore, MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Approximate Interval Between Immediate Cause (Final Onset and Death 0 Physician/ disease or condition resulting in death) Medical to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tra Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death g Unknown β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Smothers autopsy perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 Signature ause of death (Item 23a) (Type, Print) 30. Name and address of person who complet rive Bel Air mo rina Miktyans Upper cheso Lava 500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lillian Ruth Seyda JULY 2012 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Square LOSE do l'E If Under 1 Year 8. Date of Birth Social Security Number (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) Hours 1 M 200 Months Days Min 92 231-07-3483 Yrs. Director 1919 Norfolk, Virginia August 21, Usual Residence of Decedent 10c. City, Town or Location 10h Counts 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be notified at 28a-f show Nottingham Director Maryland Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 5 D Mopec Circle United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify: þ Specify: White 3€XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate State Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Ruth Guess William Oscar Smith ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 D Mopec Circle Nottingham, Maryland 21236 Teresa Seyda (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel—Bel Air July 30,2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation 8800 Harford Road Parkville, Mar 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-vailure. List only one cause on each line. Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Du to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 3 ☐ Probably 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗹 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: A 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

Dr. Mohamad

chab 9000 Franklin Square Drive Baltimore MD. 21237
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chehab

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B		Physicia Medic		1. Decedent's Name (First, Middle, JOSEPHINE R. SC								2. Date of De Month	Da		rear	3. Time of Death
	_/	Examin		4a. Facility Name (If not institution, s	AVEN			LOC	H RA				В	. County of	ORE	
1 d =		Funeral Director		216-12-6503	6. Sex 7. Ag 1 □ M 2 X XF	e (In yrs. la 89	ast birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Mar 1	th a <i>y, Year)</i> 8,19	23	9. Birth Coun	place (State or Foreign htry) D
Josephi		aryland a-f show fled at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim	ore	10c. City	y, Town or Lo	cation Balt	imor	e Co	Jnty					10d. Inside City Limits 1 ☐ Yes 2XX No
	:	of the man of the man of the man of the most of the mo	Funeral Director	10e. Street and Number 8724 Blairwood	Rd. Apt. A2			10f. Zip	Code 2123	 6			10g. Ci	10g. Citizen of What Country?		
schuchman	N LE LA LA VANCALIA DE LA CARRACTE D						- 1					cify Yes or No- Rican, etc.)	D- 14. Race - Amer Black, White			
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4	7	ygiene ygiene her tha		8 yrs.	N/A		Wai	tress						per K	ett	le
36	land	be tiled lental H rked ot tic even	To Be	17. Father's Name (First, Middle, La Carmello Tumine								(First, Middle Unknow		Surname)		
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-		F Health Health Hem 27 Other t	3	Donald Schuchma 20a. Method of Disposition		20b. F	Place of Dispo	osition (Nar	ne of	- 1		Date	_	ocation - C		. 21236 own, State
4	imore,	rage Timent of tant: If i		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 Removal from State pecify)	Me	emetery, crei tro Cr	emato	ry,	Inc		1-2012		ltimo		Md.
00	Baltı	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Lie	sakn		22	2. Name ar 74				ssahn F Balti	une: more	ral Ho , Md.	ome 21	236
3				23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that cause nly one cause on each lin	d the deat	h. Do not ent	er the mod	e of dying							Approximate Interval Between Onset and Death
	~∹P ∦	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequ	uence of):		76	2	FAIL	JRE TO	THR]	VE	+	
B	anga menger	Examiner	<u>.</u>	Sequentially list conditions,	b. <u>50</u>	ve	50	7	M	2	7-7					
X	7	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequ	uence of):		te	bi	12			TEST:		
V	D	oe execuician and		that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):	5	RECT	'AT. C	ANCEI	BI BI	2	BY MEDIC	AL EXAM	INER
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to mi	Box 6	To the hospital or Attending Priysican: The law requires that the beam certificate be executed within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	☐ Ectopic ☐ Other (s _f		У		CEKII.		23d. Date Mont		very Day Year
4	, С	es mar m signed by I be detac		Part II. Other significant condition	ns contributing to death I	out not res	sulting in the	underlying	cause giv	en in Pa	: 1. 					he cause of death?
La	cords	iaw requir ias been s 2 should	Completed by	Decubi	hus	W	ce	-{				24a. Was	an opsy	24b. We	ere auto	opsy findings available ompletion of cause of
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ľ	n of	th. After the funeral	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig		ury iy, Year)	28b. Time o injury	f 2	8c. Injury work 1 \square	∕at ? Yes 2 □		28d. Describe	how inju	ry occurred		
	Division of Vital Records,	Hospital of Attending Priysician: The law 24 hours after death. Enneral Director: After this certificate has lated filled in by the funeral director, page 2 s	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic only one) 28b. Time of injury (Month, Day, Year) 28c. Injury (Month, Day, Year) 28b. Time of injury or At home, farm, street, factory, office building, etc. (Specify)									28f. Location City or To			or Rura	al Route Number,
ľ		n 24 hours	Medical	(Check 2 Medical Ex	Physician: To the best o caminer: On the basis of Nurse Practioner: To the	examinatio	n and/or inves	stigation, in	my opinic	n, death o	occurred at	the time, date	and plac	e, and due t	o the ca	ause(s) and manner stated.
4		o the within 2 To the comple		29b. Signature/and title of certifier	mo	AH,	R		License		500	03		ate signed (
		6		30. Name and address of person w	rho completed cause of	death (Item	1 23a) (Type,	Print)	En	nge	2 R	d. F.	3a1	F. 1	nj	21234
		Sta Registra		31. Date filed (Month, Day, Year)		rar's Signa	ture	ark	/							

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>D</u>ay Physician/ Month George J. Steve, III July 2012 8:00 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford County 400 Harrington Road 8. Date of Birth (Month, Day, Year) March 7, 1932 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Pennsylvania 222-18-6775 80 Director Usual Residence of Decedent 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Harford County Bel Air 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21015 United States 400 Harrington Road items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ò 2 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White "natural", Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Davinson Transfer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Cora Virginia Sutton George Robert Steve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is 1237 Whispering Woods Way, Bel Air, Maryland 21014 Debbie Bateman (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/28/2012 Fallston, Maryland Highview Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Bel Air B Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UREMIA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner RENAL PAILURE ENDSTAGE Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to jor as a consequence of CONGESTIVE HEART PAILURE physician and the burial-tran Due to (or as a consequence of): Physician/Medical ISCHEMIC CARDIOMYOTATTI Division of Vital Records, P.O. Box 68760 ding p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death
Unknown Month Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ACUTE MYCCARPIAL INFARCTION Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown THROMISD CYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? MYEDO DYSPLASIA 2 12 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Andra Nowaleons DOP096 JULY 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 FULFORD ME, BELAKRIMD LIOIY ANDREW NOW HOLOWSKI

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 20^{Day} PAULETTE STANNARD 2012 1:21 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY **BETHESDA** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours 579-68-1952 Director 1 M 2 XF Yrs SEPT. 12,1948 WASHINGTON, DC 63 Usual Residence of Decedent works 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 28a-f s 1 ¥ Yes 2 □ No MD MONTGOMERY **BETHESDA** 10e. Street and Number ь 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 5721 GROVSENOR LN 20814 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noı "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify BLACK If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 2YRS Elementary/Secondary (0-12) PRIVATE VETERINARIAN TECHNICIAN 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALBERT STANNARD MABEL L. MCGREGOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGORY STANNARD/BROTHER 1012 KINGS TREE DR MITCHELLVILLE, MD 20721 Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 07-24-2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. 21. Signature of Fyneral Service Licensee Juga 7474 LANDOVER RD HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Phonician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of signed by the attending physician and Ideached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autops, performed autonsy death? 1 🗆 Yes 2 🕬 Yo Hannard, Paulette Hospital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 PNo Hospital Other: ٥ 1 Tyes 1 🎾 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 24 hours after death. Funeral Director: At Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 00057124 zero, uns 7/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TROUNG BAO 10110 MOLECULAR DR SUITE 206 ROCKVILLE, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

27 2012

7/120/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ K: PPet Steven 11:10 AM 2013 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rosedaje HOSpital Franklin Square 8. Date of Birth (Month, Day, Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Mir 72 1 XM 2 □ F Director 217-36-2218 1940 Jul 17, Maryland Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits with the Maryland Director 1 Yes 2 No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 1 Eastern Avenue United States "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. by 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Truck Driver Robbins Be timore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever ည Page 1 and 2 should be nent of Health and Menta Charles Skipper Matilda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Patricia Gawlik /Sister 4138 Beechwood Rd. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jul 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 Signature of Funeral Service MO1585 22. Narce and Address of Family Funeral Alternatives Rabos 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Jastr oin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to or as a consequence of: if any, lacking to immedicause. Enter Underlying burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events pue Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at the detached for Yes 2 No g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 1 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Tes 2 No hours after death uneral Director: / Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 To the F 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) DUO 47697 20 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore, MD 21237 Year) 31. Date filed (Mo

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 12:30 P M Luta Davis Saunders 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brook Grove Nursing Home Sandy Spring Montgomery 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yea
July 18, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F Months Hours Year) Country) Virginia **Director** 96 1916 577-58-3475 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits must be notified Direct MD Montgomery Sandy Spring 1 Tes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 18131 Slade School Rd. 20860 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Examiner Black, White, etc 'natural", or 1 Never Married 2 Married à 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2X No Specify. White 3 🔀 Widowed 4 🗆 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tabulator Supervisor Federal Government Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n and Mental I is marked o ပ Annie Sedonia Walter Cochran Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Dorothy Brafford / Niece 4512 Mullen Lane, Annandale, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory | 07/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service See M00382 Rapp Funeral and Cremation Services tishet warm 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ CARDIOMYOPATHY YEAR Medical resulting in death) Due to (or as a consequence of) **Examiner** ESSENTIAL HYPERTENSION YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? detached for Pregnant at time of death Month Day Year 2 🔀 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, DIABETES MELLITUS TYPE II 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: XX Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မြ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23958 JULY 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3305 N. MEISURE WORLD BLVD., SILVER SPRING, MD BURT I. FELDMAN, M.D.,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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permit. Pages 1 Department of 1 Important: If injury or other	1	21. Signature of Fu						s of Facility	Simpli	city	Crem &	Fun Serv
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The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	by	rait II. Other sign	micani conditions	contributing to death	T Dut Hot result	ing in the d	ilderlyllig cause	giveri iii Fa				ably 4 Unknown
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After Ineral	=	27. Manner of Dea	th	28a. Date of Inju (Month, Day Y Jul 16, 2012	ry 28i	o. Time of Ir		ury at Work	Occupa		njury occurred plane involved i	n collision
tendi eath.	li j	1 Natural 2 ✓ Accident	5 Pending Investigat		19	12 hrs	1	Yes 2	No Occupa	it or air	platie ilivolved i	II comsion
frer d frer d Direct in by	ij	3 Suicide	6 Could not	28e Place of In	jury - At home	farm, stree	et, factory, office	building, et		on (Street	t and Number or Rur	al Route Number, City
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	4 Homicide	determine	ed (Specify) Wo	ods						s Drive, Gaihersbi	urg, MD
Hos 24 hc Fun	<u>a</u>	29a. Certifier (Check only	CertifyIng Physic	clan: To the best of m	y knowledge, d	death occur	red at the time, o	date and pla	ace, and due to the	cause(s)	and manner as state	d.
o the	Medical	one) 2 🗸	Medical Examine	er: On the basis of examination of examination of examination of the e	mination and/o	r investigat	ion, in my opinio	n, death oc	curred at the time,	date and p	olace, and due to the	e cause(s)
FSFO	ž	29b. Signature and	title of certifier) -			29c. Licen	se number		290	d. Date signed (Mon	th, Day, Year)
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do		30. Name and add	ress of person who	completed cause of d	leath (Item 23a	1)					····	
Y		Patricia Arc	nica-Pollak Mi	D. Assistant M	ledical Exa	miner	900 W. Balti	more Str	eet, Baltimore	, MD 21	1223	
	tate	31. Date filed (Mon		32. Registra	r's Signature							
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3. Time of Death

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death JULY 23,2012 9:10P DORIS LIGHTY SETIEN 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death HARFORD BEL AIR BRIGHTVIEW ASSISTED LIVING If Under ge (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Days Hours Min. 174-20-4944 85 1 □ M 2 **X** F Yrs. PENNSYLVANIA 9-14-1926 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Tes 2 No BALTO. PERRY HALL MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21128 USA 9 BROOK FARM COURT APT.H 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates. WHITE 1 Yes 2 No Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working BALTIMORE COUNTY life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PUBLIC SCHOOL 12 6 TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARY C. POWERS ARTHUR L. LIGHTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARC SETIEN SON 20883 YELLOWBLOOM COURT ASHBURN, VIRGINIA 20147 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 7-25-2012 GLEN BURNIE, MD. ATLANTIC CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service ce ee 9705 BELAIR ROAD NOTTINGHAM, MD.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Due to (or as a conseq ance of) disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Pregnant at time of death q Unknown 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical **Examiner**

by the attending physician and stached for use as the burial-transit

detached for use

page 2 should be

the funeral director,

filled in by

has

after death. Director: After this certificate

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f show

23a

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Il Hygiene.

and N

item 27

Department of Important: If it any injury or o

within 72 hours after

Baltimore, Maryland 21215-0036

must be notified at

Examiner

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traumatic event,

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Completed

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Examine Be Completed by Physician/Medical ဂ္

Certificate:

25. Was case referred to medical 27. Manner of Death Medical 29a. Certifier

examiner?

1 Tyes

Natural

Accident

4 Homicide

Suicide

within 24 hours a

To the Funeral C

completely filled To the I State

Hospital

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HRG

1 Yes 2 No 3 Probably Yunknown 24a. Was an autopsy

performed

28d. Describe how injury occurred

 ☐ Yes

4 Nursing Home 5 Residence

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

ASSISTED LIVING

Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of (Month, Day, Year) injury 5 Pending M Investigation 6 Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

w

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Other:

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

determined

D3550

29c. License number

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d, Date signed (Month, Day, Year) 24 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Pfint)

31. Date filed (Month, Day, Year) 2012 27

32. Registrar's Signatu

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Voar **Physician** 0027 AM Charles ٤ 18 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MRCH 27,1939 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 □ F 219-26-3330 73 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene.
nt: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ¹

X
Yes 2 □ No Director MD. BALTIMORE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code Funeral 525 S. CURLEY STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Tes If Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo 2 Specify: 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) RYDER TRUCK Elementary/Secondary (0-12) 10TH College (1-4 or 5+) MECHANIC INSTRUCTOR COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES SISK NORA JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN L. SISK **SPOUSE** 525 S. CURLEY STREET BALTO.MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 Durial 2 Cremation 3 Removal from State ST. STANISLAUS 7-21-2012 BALTO. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON INC. (el **6224 EASTERN AVENUE** BALTO.MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due t (or as a conse) nce of): **Physician** bours disease or condition resulting in death) Medical/المر Examiner Due t (or as a consequence of): SYDD Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed and burial-trai resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medical the use as t IF FÉMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No Yes 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown disease arteni Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 1 🗌 Yes 1 Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes -2 No 1 Inpatient 2 ER/Outpatient 3 DOA ρ this Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 🗌 No death. after death Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide ō within 24 hours a the Hospital 29a, Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) соттретел 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number MDIPHD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wiltona 4940 Eastern Avenue, Baltimore, MD, 21224 Marie iled (Month, Day, Year) UL 2 7 2012 32. Registrar'

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0:25 PM Physician/ John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral Hours Min (Month, Day, Year) Maryland Director 212-20-5148 88 8 th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland fant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 627 Deering Road 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. WW I I δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2√D(No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) owner TV_Repair 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ George Smith Carrie Geller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen M Smith spouse 627 Deering Road Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc 7/30/12 Baltimore Maryland 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Funeral Service La 3111 Mountain Road Pasadena MD 21122 23a. Par 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronar Physician/ disease or condition Medical resulting in death) e of) Examiner 20415 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 389 12 2012

Registrar
DHMH 17 Rev 06-2011

State

7846

31. Date filed (Month-Day, Year)

Suite

Glen Burnie

30. Name and address of person who completed cause of death (Item 254) (Type, Print)

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Division of Vital Records, tal or Attending Physician: The law requirers after death. at Director: After this certificate has been siled in by the funeral director, page 2 should be	o Be	examiner? 1 ✓ Yes 2 No	tal: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other Nursing	Home 5 R	esidence 6 🗸 Othe	r; Scene
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Divis To the Hospital or Ai within 24 hours after of To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examiner:On	the basis of examination a manner stated.	and/or investig	ation, in my opinion,	death occurred at	the time, date an	d place, and due to th	e cause(s)
5 7 8 7 8	Me	29b. Signature and title of certifier	mailio stated.		29c. License	number	- :	29d. Date signed (Mo	nth, Day, Year)
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		30. Name and address of person who comp	,	-	O.M. Pallimar-	Street Baltim	ore MD 242	23	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d, per phy, g929 /-27-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 2012 a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral Director** 1 □ M 2 💢 F 78 NNESSEE Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 ▼Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furreral Service 10220 Guilford Kd disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ umonia disease or condition resulting in death) Medical r as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a co equence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death. 25. Was case referred to medical Be Vital 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: The conference of the cause of the cau 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00062435 7/25/2012 30. Name and address of Rockville, MI) 20850 ate filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DORIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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100	Funeral		5. Social Security Number	6. Sex 7. Age (In	yrs. last birthday)	SILVER If Under 1 Year		Hrs. 8. Date of Bir	th	9 Birtho	lace (State or Foreign
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The T	page	Com						autop perfo 1 \sum Yes	rmed? de	eath?	npletion of cause of
VILCII /sician;	certifi rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth		Check only one)			
g Phy	er this ieral di	e: 70	27. Manner of Death	28a. Date of injury	2 ER/Outpatien 28b. Time of	28c. Injur	y at	ng Home 5 Resid	lence 6 Other		
VISION or Attendin	leath. or: Aft the fur	ertificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	gation	ar) injury	M 1 🗆	Yes 2 No		, ,		
or At	after d Direct I in by	Cert	4 Homicide determ		At home, farm, stre pecify)	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural I	Route Number,
the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying	Physician: To the best of my k	nowledge, death o	ccured at the time	, date and place	ce, and due to the car	use(s) and manner	as stated	,
the H	thin 24 the Fi mplete	Mec	only one) 3 Certifying	xaminer: On the basis of examin Nurse Practioner: To the best	nation and/or invest	igation, in my opinion leath occurred at the	on, death occur e time, date an	red at the time date a	nd place and due	to the caus	hateta rannem hac (a)as
P	≱ ℃ S		29b. Signature and title of certifier			29c. License	56 (3)		29d. Date signed	(Month, D	
	2		30. Name and address of person v	who completed cause of death	(Item 23a) (Type, P		20 (.2	-	1(20	2012	
	0		NARITA SI	IRANA, MD 2	2101 EAST		ON ST F	ROCKVILLE,	MD 2085	2	
	Stat Registra		31. Date filed (A211) D2012	Server 32. Registrar's S	and the second						

THIBAULT, JULIETTE

Director Direct	hplace (State or Foreign intry) MA 10d. Inside City Limits 1 Yes 2 X No
Physician Medical Examiner 1. Decedent's Name (First, Middle, Last) Juliette Alice Thibault Juliette Alice Alice Thibault Juliette Alice Thibault Juliette Alice Thibault Juliette Alice Thibault Juliette Alice A	7// AM Arundel hplace (State or Foreign untry) MA 10d. Inside City Limits 1 □ Yes 2 ☒ No
Examiner 4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center Baltimore Washington Medical Center Glen Burnie Anne A Anne A Anne A Anne A I Under 1 Year of Under 24 Hrs. (Month, Day, Year) July 13 1928 9. Birth (Month, Day, Year) July 13 1928 9. Birth (Month, Day, Year) July 13 1928 10c. City, Town or Location Pasadena 10d. Courty Maryland Anne Arundel 10e. Street and Number 1561 Guerdon Court 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Xho 1 Yes 2 Xho 1 Yes 2 Xho Specify: We have or barely of the surface of the	hplace (State or Foreign MA 10d. Inside City Limits 1 Yes 2 X No
Baltimore Washington Medical Center Glen Burnie Anne A S. Social Security Number 020-22-8720 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number 10a. State Industry Min. July 13 1928 Social Security Number (Float State Sta	hplace (State or Foreign untry) MA 10d. Inside City Limits 1 Yes 2 X No
Funeral Director Social Security Number 10	hplace (State or Foreign untry) MA 10d. Inside City Limits 1 □ Yes 2 🏋 No
Director Director	MA 10d. Inside City Limits 1 ☐ Yes 2 🔀 No
Property of the part of the pa	1 🗌 Yes 2 💢 No
Maryland Anne Arundel Pasadena	
10e. Street and Number 10g. Citizen of What Court 10g. Citizen of North 10g. Citizen	
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americal Relationship (Type, Print) 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ir (Give kind of Work Name (First, Middle, Last) 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16. Monten's Name (First, Middle, Maiden Surname)	
Specify Spec	
15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16. Kind of Business/Ir (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) Wilfred Lapre 18. Mother's Name (First, Middle, Maiden Surname) Nerea Trahan 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Pauline Barbour (daughter) 1561 Guerdon Court, Pasadena, MD 21122 20a. Method of Disposition (Name of cemetery, crematory or other place) 157 Guerdon Court, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 158 Decedent's Sual Occupation (Give kind of work done during most of working life. DO NOT use retired) Househier Househier 159 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip Pauline Barbour (daughter) 20c. Location - City or Town, State, Zip	hite
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Trahan 17. Father's Name (First, Middle, Last) Wilfred Lapre 18. Mother's Name (First, Middle, Maiden Surname) Nerea Trahan 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) Pauline Barbour (daughter) 1561 Guerdon Court, Pasadena, MD 21122 20a. Method of Disposition 1 Burial 2 **X Cremation 3 ** Removal from State of Disposition (Name of Cemetery, Crematory of other place) 1 Burial 2 **X Cremation 3 ** Removal from State of Disposition (Name of Cemetery, Crematory Inc. Specify) 18. Mother's Name (First, Middle, Maiden Surname) Nerea Trahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Pauline Barbour (daughter) 20b. Place of Disposition (Name of Cemetery, Crematory of other place) Metro Crematory Inc. Baltimore, Figure (First, Middle, Maiden Surname) Nerea Trahan 19a. Informant's Name/Relationship (Type, Print) Pauline Barbour (daughter) 20b. Place of Disposition (Name of Cemetery, Crematory of other place) Metro Crematory Inc.	old
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1 Burial 2 Tycremation 3 Removal from State Metro Crematory Inc. July 27 Baltimore,	Town, State
2012	
21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 2	lome, P.A. 21122
23a. Part 1. Enter the disease, or complications that Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)	Onset and Death
Examiner Pulmonary Fibrosis	
Sequentiary instructions, If any, leading to immediate Due to (or as a nonsequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
e pe es es es es es es es es es es es es es	
9	
OP OF CONTROL OF CONTR	very Day Year
Sport at the sport of the sport	the cause of death?
\$\frac{1}{2} \frac{1}{2} \fra	obably 4XUnknown
The state of the s	opsy findings available ompletion of cause of
autopsy performed? 1	2 🗆 No
25. Was case referred to medical examiner? 1	fv)
27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 Natural 5 Pending 28d. Describe how injury occurred	<i>2</i>
27. Manner of Death 27. Manner of Death 28a. Date of injury 28b. Time of injury 28c. Injury at work? 28	al Route Number
28f. Location (Street and Number or Hura) Street	ii Hodie Nambel,
Second of the control of the cause (s) and manner as state of the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and manner as the time, date and place, and due to the cause (s) and the time, date and	
only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 29b. Signature and title of certifier 29d. Date signed (Month,	ause(s) and manner stated
Main Campula CRIP R118455 7/20/12	ause(s) and manner stated stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Hospitch Dr. Glen Burne, MD 21061	ause(s) and manner stated stated. Day, Year)
State Registrar 30/ Hospital Day Year) - 32. Egistrar's Signature 31. Date filed (Month, Day Year) - 32. Egistrar's Signature 32. Egistrar's Signature 32. Egistrar's Signature	ause(s) and manner stated stated. Day, Year)

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umoo E. Toma		1- For State	ate of Ivialyi		ficate of i		IG WICH	itarriyg		Reg. No.	4	0 1 2	2 238
Physici ledical Exam	an/	1. Decedent's Name (First, Midd James E.	-	szewski				- 1	Date of De Month July 23, 2	ath Dav	Year		Time of Death 1015 hrs
		4a. Facility Name (if not institution 1559 Marco Drive	on, give street and n	umber)	4t	o. City, Town, o Pasadena	or Location			4c.	County of nne Aru		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Ye				,	1	Foreign	place (State or
Director		216-04-8326	1 M 2 F		35 Yrs.	Months Da	ys Hours	s Min.	03/3	30/19	77	Count	try) MD
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location	n						11	0d, Inside City Limits
A	_	Maryland Anne	Arundel			Pasade	ena					1	Yes 2 X No
Maryland 28a-f show d at once,	Director	10e. Street and Number			i	10f. Zip Code			Т	10g. Citiz	en of Wha		
death with the Maryland or items 23a or 28a-f sho must be gotified at once.		1559 Marco Dri	ve				211	122				USZ	4
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ter dea			1 Yes	2 X No	1 1 1	res 2 X N	o specify:	:			Specify:	te	
2 hours afte "natural", Examiner	d by	15. Decedent's Education (Spe	or Dates:		6a. Decedent's	Usual Occupa	ation (Give	kind of wor		16b. Ki	16b. Kind of Business/Industry		
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-003 within giene.	шо	12 17. Father's Name (First, Middle,	Last)			ar ren		r's Name (F	irst. Middle.	Maiden S		<u> </u>	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Walter E.	Tomaszev	ski			Doni	na	Glas	ser	•		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fah traumatic event, the Medical Examiner must be notified at once	မှ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stre	et and Nun	mber or Rur	al Route Nu	mber, Cit	y or Town	, State, Z	ip Code)
MD and 2 sho salth and em 27 is raumati		Walter E. Toma 20a. Method of Disposition	aszewski (Г г	ate		ocation - 0		wn. State
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	To the control of the												
Dept.	0 10	Muschell	Hall	(red)	3	8111 Mo	untai	Sta. n Road	llings d, Pas	s Fur sader	neral Na, M	D 21	P.A. 122
Physician		23a Part I. Enter the disease, or failure. List only one cause		aused the death. D								rt .	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		Intoxica consequence of):	tion							-	Death
		Sequentially list conditions,	b	consequence or).									
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876 rtificati ing phy as the	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ne 1 Live I		2 Feta	I death 3	Ectopi	c pregnancy	/		. Date of d Month	Day	Year
Box 68760, c death certificate be the attending physic ed for use as the bur	Sici		4 Pregr known 9 Unkn	nant at time of death	5 Othe	(Specify)							
D. B. t the de by the ached f	Physi	Part II. Other significant condit		death but not resu	Ilting in the un	derlying cause	given in Pa	art I.	23e. Did t	tobacco u	ise contrib	ute to the	cause of death?
Ords, P.C. w requires that as been signed be should be deta	d by								1 Ye	es 2 🗸	No 3	Probab	ly 4 Unknown
rds v requi s been should	Completed								24a. Was auto				sy findings available pletion of cause of
Reco	E			-					perfo 1 ✓ Yes	ormed? 2 No) de	ath? ✓ Yes	2 No
tian: Certific certific ector, p	Be	25. Was case referred to medica examiner?	Il Inspitals -				Other	(Check only		7		1	
Division of Vital Records, P.O. is to Attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled	ျ	1 Yes 2 No 27. Manner of Death			R/Outpatient Bb. Time of Inju		ury at Work	Nursing F	d. Describe				cene
ion o tending eath. tor: Aft the fune	ijo	1 Natural 5 Pend		7-23-12 f	,	· 1	Yes 2 🕱		ıknown	-	,		
ViSic or Atte her dez irrecto	fical		d not be 28e. Plac	e of Injury - At home	e, farm, street,		building, et	tc. 28					Route Number, City
Division of the pital of the pi	Certification:	4 Homicide deter	rmined (Specify)	found at	home			P	asade		559 M	arco	Dr.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		Chook only	hysician: To the bearing										ause(s)
To t With To t	Medical	29b. Signature and title of certifie	and manner s				se number		, _,				, Day, Year)
		Pat A	- Paga			0.C	.M.E.			July	24, 201	2	
_		30. Name and address of person								1		_	-
		Patricia Aronica-Pollal	k MD. Assist	ant Medical Ex	aminer 9	00 W. Balti	more St	reet, Balt	imore, M	1D 2122	23		

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

31. Date filed (Month 2017, Year) 7 2012

S. Juli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Ma	ryland		artment <i>tificate</i>			and M			0.0	2	238	78
			Registrar 1. Decedent's Name (First, Middle, La	ist)		Cer	incate	OIL	Caur		2. Date of Dea			6	3. Time of De	
	Physicia Medic		Stanley K. Ulri	ch							Month	2	2 2	12	8:35	Рм
	Examin		4a. Facility Name (if not institution, giv						Location o	of Death		4	c. County of I		×17	
	-1-		Suburban Hospit 5. Social Security Number 6.8		(In vrs. la:	st birthday)	If Under	hes	da If Under	24 Hrs.	8. Date of Birt	th_	Montg		ace (State or Fo	oreign
	Funeral Director			1 X M 2 □ F 84		Yrs.	Months	Days	Hours	Min.	(Month, Da)	y, Year)		Countr		
	no o		Usual Residence of Decedent 10a, State 10b, County			, Town or Lo	nation				0-3-13	720	1		d. Inside City L	Limits
	aryland a-f sh fied a	Director	MD Montgo			ver S								10	1 Yes 2	
	or 28%	Dir	10e. Street and Number	,			10f. Zip	Code	_			10g. C	Citizen of Wha	at Counti	ry?	
	with 1 s 23a ust b	Funeral	12520 Marie Cou	rt			20	904				Ur	nited S	Stat	es	
	death ritem ner m		11. Marital Status	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🔀 N	er in U.S.	. 13. \	Vas Dece d e f Yes, speci	ent of Hi fy Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto F	ify Yes or No- lican, etc.)		14. Race - A Black, \	America White, et		
336	al", or	Completed by	1 ☐ Never Married 2 🛛 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates.	0	1	∣ ☐ Yes 2	X No	Specify:				Specify:		White	
21215-0036	hours natur dical 6	olete	15. Decedent's (Specify only highest g	Education	T	16a. Deced	dent's Usual kind of work	Occupa	ation	of workin	a	16b.	Kind of Busin	ness/Indu	ustry	
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2	Hygier Hygier other I	Be C	1 Z 17. Father's Name (First, Middle, Last)		1	Own	SLUIE		18 Mothe	er's Name	(First, Middle,					
an	be file ental rked c	2	Aaron Harry Ulr								Krasne					
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)							Route Numbe					
Σ	nd 2 s ealth m 27		Selma B. Ulrich	- Wife					ourt,			-			d 20904	4
Baltimore,	ge 1 a it of H if ite or oth		20a. Method of Disposition 1		CE	ace of Dispo emetery, cren	natory or ot	her plac			ate		Location - Cit			d d
I‡i.	artmen ortant:		4 Donation 5 Other (Spec	**		ig Dav					-2012 nzansk				, Virg	inia
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licer	Brad Sme	tzer										d 2085	2
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused to	he death										Approximate Interval Betwe	
20	Physician/		Immediate Cause (Final disease or condition	Ather	05	Clev	otic	Ca	rond	Wy!	/ascula	V	Visca		Onset and Dea	
, Santa	Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):				1	-					
3		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequ	ence of):		_								
2	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,	·											
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200	the the	edical		d												
88	ss that the death certifics igned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			7						23d. Date	of delive	ry	
€ Š	death e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Other (spe		;y				Month	۱ ا	Day Yea	ar
0.	at the d		9 ☐ Unknown Part II. Other significant conditions		t not resi	ulting in the u	ınderlyina c	ause div	en in Part	I.	23e Did t	ohacco	use contribu	ite to the	e cause of dea	th?
17, B.	requires that the been signed by the should be detach	d by	Taren. Other signment conditions	ooming to down be		g									ably Un	
ords		Completed by									24a. Was		24b. We	re autop	sy findings ava	ailable
Se C	The law ate has l page 2 t	omp									auto perfo 1 \square Yes	ormed2	dea	or to con ath?] Yes	npletion of cau 2 □ No	ise of
Vital Rec	ian: Ti rtifical ctor, p	Be C	25. Was case referred to medical examiner?					_	ace of Dea	th (Check			110			
7 ==	Physician: this certific ral director,	မ	1 Yes 2 No	Hospital:					4 🗆 N		me 5 🗌 Resi			Specify)		
To	ding P n. After t funera	ate	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		28b. Time of injury	т 28 М	3c. Injur work		- 1	8d. Describe	how inj	ury occurred			
45 sion	or Attending after death. Director: After in by the fune	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injur	y - At ho	me, farm, str			103 2 -	_				or Rural	Route Number	5
SE C	tal or a safter al Dire	Ce	4 - Homicide determine	building, etc.	(Specify,)					City or To	wn, Sta	ite)			
I	Hospital	Medical	(Check 2 Medical Example 1)	ysician: To the best of r miner: On the basis of ex	amination	and/or inves	stigation, in n	ny opinio	on, death o	ccurred at	the time, date:	and pla	ce, and due to	the cau	se(s) and mann	ner stated
7	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Ĭ	only one) 3 Certifying Nu 29b. Signature and little of certifier	irse Practitioner: To the	best of m	ny knowledge			he time, da e number	ite and pla	ce, and due to	_	use(s) and mar Date signed (/			
	FSFÖ		1 tstril	X	N	N)	1	10	944	1391	1	T	14. 22	,21	012	
			30 Name and address of person who	completed cause of de	ath (Item	23a) (Type, I	Print) C	603	01	160	مراج م	n 0	40.	1 =	1 Mar	$\overline{}$
10			31. Date filed (Month, Day, Year)	32. Registral	's Signat	tre tree	FV D	508	014	060	utsku	*/ \"	1/ 130	nesc	Wa, IriL	رر
	Sta Registr		JUL 2 7 2012	General B	Jugital	arke	,									
XX DH	MH 17 Rev 06-	2011			1											

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 25 1:25 PM Ulenurm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Min. Country) **Director** 216-34-6963 1 🔀 M 2 🗆 F 1/14/1939 Estonia 73 er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes XX No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 21206 Estonia 4012 Fleetwood Avenue be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4^{College (1-4 or 5+)} l Hygiene. Elementary/Secondary (0-12) Montgomary Ward Manager Ith and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linda Gerbe ပ္ Arnold Ulenurm t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Elk Forest Road Elkton MD 21921 Shelby Roth/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of July 30,2012 20c. Location - City or Town, State Department of I Important: If ite any injury or of cemetery, crematory or other pla Gardens of Faith 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD . Signature of Funeral Service Licensee Leonard Adgress of Facility, Inc. 5305 Harford Road 21214 Baltimore MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any hading to immediate cause. Enter Underlying Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy perform this certificate Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP (Q Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

0 4

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 .45 A M Jelle A. C. Vanderveer 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORD AIR HEALTH AND REHABILITATION CENTER ALY 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min. 01/11/1929 Dutch Indonesia Months Davs 1 🖾 M 2 🗆 F 049-32-5360 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State death with the Maryland must be notified at Director 28a-f Fallston 1 Yes 2XNo Harford MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 items 23a Funeral 21047 USA 1815 Oakmont Rd 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if item 27 is marked other the any injury or other trainment. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify If Yes, Give Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Electronic and Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Design Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Roosje Djadeen Cornelius Vanderveer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, 1815 Oakmont Rd., Fallston, MD 21047 Sheila Hicks - POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donaffon 5 Other (Specify) 07/25/2012 Glen Burnie, MD Atlantic Crematory 21. Signatur of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home, 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last bunial-tran Due to (or as a consequence of) attending physician for use as the bunal Physician/Medical or Attending Physician: The law requires that the death certificate be IE FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death led by the atter detached for u in the past 12 months? Month Day Year Pregnant at time of death Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certificate 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Other 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1-Natural iniury 5 Pending Investigation ☐ Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t determined Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 the only one) 29b. Signature and title of certifie ē M.D Benjamin Lee, mp 669 Revolution

State Registrar illed (Month, Day, Year)
JUL 2 7 2012

DHMH 17 Rev 7/2009

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** anda 11st If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 8. Date of Birth Age (In vrs. last birthday) **Funeral** Months Min. Director 23a or 28a-f show 10b. County 10d. Inside City Limits Town or Location 10a. State 10c. City. at be filed within 72 hours after death with the Maryland **Funeral Director** Examiner must be notified 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10e. Street and Numb 2618 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No If Yes, Give Year or Dates Specify Blac 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life_DO NOT use retired) (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be me (First, Middle. ပ 20b. Place of Disposition (Name o 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) ture of Funeral Service Licensee 21. Sign 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition resulting in death) Medical o (or as a consequence of **Examiner** Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trail that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death been signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I should be 4 Unknown 2 No 3 Probably 1 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has filled in by the funeral director, page 2 death? 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural ☐ Accident ☐ Suicide Investigation 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Detifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29d. Date signed (Month, Day, Year) 2 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY Pay 20 Year 4:50 P M WALKER LOUIS WILLIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S UPPER MARLBORO 9402 FAIRHAVEN AVENUE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 416-46-9232 74 **Director** 1 X M 2 □ F ALABAMA OCT. 11 1937 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 1 XYes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n Funeral 23a with 20772 USA 9402 FAIRHAVEN AVENUE items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. BLACK ori þ 1 Never Married 2X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " alth and Mental Hygiene.
27 is marked other than r traumatic event, the M College (1-4 or 5+) Elementary/Secondary (0-12) SUPERVISOR METRO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be NOLAN WALKER ROSTE REVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 9402 FAIRHAVEN AVENUE UPPER MARLBORO, MARYLAND 20772 IDRIENNE WALKER/WIFE other 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State 10 F 10 cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or 4 Donation 5 Other (Specify) 7/30/2012 CHELTENHAM, MARYLAND VETERANS CEMETERY ! 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME, INC. phnel 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner COPD Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-tran physician and Due to (or as a consequence of): resulting in death) Last or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Por in the past 12 months? Month Day Year Pregnant at time of death the a Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 🗌 No 1 Yes Yes 2 XNo 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{X}\)Residence \(6 \text{ \text{\text{Other}}}\) Other (Specify) 1 Yes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending work?
1 Yes 2 No death. M the Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital within 24 hours a Medical

State Registrar 29a. Certifier

only one)

30. Name and addre

29b. Signature and title of

3

WRIGHT

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

1500

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D69916

FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

29d. Date signed (Month, Day, Year) JULY 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA MORR 14 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year, -0896 Director 1 M 2 M 50 Yrs 9 Jan Usual Residence of Decedent 28a-f show 10b. County with the Maryland ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No itimas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral North 21215 items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status er than "natural", or iter the Medical Examiner ed Force Black White etc. 1 Never Married 2 Married 2 No ò Yes Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 sable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ lian irainia 7 tines permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic VIC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MCAdams ircle North Baltimore, Maurice :daecomb Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Surial 2 Cremation 3 Removal from State Mills 2017 Wings 4 Donation 5 Other (Specify), 21. Signatur of uneral Service Home 22. Name and Address of Facility Fuxera MD 21213 altimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ SOUTHOUS CELL CARCINOMA OF LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial ding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ξ 5 Other (specify) Month Day Year Pregnant at time of death detached by the Unknown g Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🗹 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate i 2 N 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital _ 2 No Other: ဂ္ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature an 29c. License numbe 29d. Date signed (Month, Day, Year) , Sh

Registrar DHMH 17 Rev 06-2011

State

30. Name and ac

ALFREDO

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

lontereo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY Physician/ James C. Wildy 2012 1:27 AM 23 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SIMAL HOSPITAL OF BALTIMORG BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Director 220-20-3654 1 ₹M 2 □ F 4-17-1927 VA 85 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 6633 HuntersWood Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: African-American 1 Yes 2 No Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed 10th Trucker Driver Be 18. Mother's Name (First, Middle, Maiden Surname) Helen E. Campbell 17. Father's Name (First, Middle, Last) ဂ္ John C. Wildy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6439 Western Star Circle, Clarksville, MD 21029 Belinda Ward/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wildy Family Cemetery 7-31-2012 Heathville, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPOUDLEMIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 3 GASTROINTESTINAL BUEEDING EFRACTORY LOWER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of the attending physician and the for use as the burlal-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery signed by the atter Id be detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URINARY TRACT INFECTION, DISPHAGIA. PLEURAL EFFUSION cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC KIDNEY DISEASE STAGEY, CORONARY ARTERY DISEASE autopsy performe HYPERTENSION, DIABETES MELLITUS TYPE 2 After this certificate 1 ☐ Yes 2-☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To Y-☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending Matural Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shaehamk Georg, MBBS, PGY-2 July, 23, 2012 KES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHANK GARG, SINAI HOSPITAL OF BALTIMORE, 2401 W BEWEDERE AVE, BALTIMORE, MD-21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Bener B. Jakes

ORIGINAL

DHMH 17 Rev 06-2011

Registrar

12-05536 Eleanore Mary V	\/hit/	Please Type or Print in Blace State of Maryland /						ible.	
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Medical Exami		Elegnore Mary	Wh	rite			Month I July 24, 201	Day Year 12	1020 hrs
)		4a. Facility Name (if not institution, give street and number) 4410 Findlay Avenue		4b. City, Tow Baltimor	n, or Location o	of Death		4c. County of Death	
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Baltimore, permit. Pages 1 at Department of Hee Important: If ite	Ì	21. Signature of Funeral Service Closs see	4. 22	2. Name and Add	dress of Facility	Ho	well	Funero	Il Home
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bl	ı	30. Name and address of person who completed cause of dea	th (Item 23a)	· · · · · ·					

State 31. Date filed (Month, Day, Year)
Registrar JUL 2 7 2012

32. Registrar's Signature

OCME

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

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I title of certifier	-, M. D.			29c. Licens				29d. Dat		(Month, i	Day, Year)	

9000 Franklin Square Drive Baltimore MD. 21237

State Registrar

DHMH 17 Rev 06-2011

29a. Certifier only one) 29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07/23 Linda Crawford Williams ^{Day}012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Center Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Hours 0/51/29/1956 455-11-4331 56 TХ Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland at by Funeral Director notified MD Prince Georges Greenbelt 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r 8695 Greenbelt Road 20770 USA permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Deli Clerk Food Services 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elbert Crawford Sr Zelma Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin L. Williams husband 8695 Greenbelt Rd Apt 102 Greenbelt MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7/25/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySimplicity Crem & Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD e of Funeral Service License Crem & Fun Serv Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest 23a. Part 1. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ letastatic mont Medical resulting in death) **Examiner** ingred Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital of Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth 2 □ Fetai ueai □ Pregnant at time of death Live Birth 2 Fetal death in the past 12 months? detached for Month Year Day 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate Yes 2 No ector: After this certific by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1- Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Die within 24 hours after

To the Funeral Di e Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 0

Registrar

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State

31. Date filed (Month, Day, Year,

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se of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend & 3 Per PHY G930 8/03/2012 III. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2012 Manning Wheeler Ju1v 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Hours

State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 12:10 A Verme11 Medical 4a. Facility Name (if not institution, give street and number) Examiner Holy Cross Hospital 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 577-62-1078 1 M 2XXF 66 Nov. 27, 1945 Washington DC Usual Residence of Decedent 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Prince George's Clinton MD 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 20735 9506 Telico Pl. United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 X Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (USDA) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government traumatic event, the Employee Relations Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Manning Nove11a Hines Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Horner Pl.SE, Washington D.C. Michele A. Wheeler / Daughter 20032 27 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Uniformed Sers. Univ:07/25/2012 Bethesda, MD Signature of Funeral Service Lie 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 totolin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ RESPIRATORY ARREST Medical Due to (or as a consequence of) Examiner ADVANCED ADENOCARCENOMA OF UTERUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) g physician and as the burial-transil Cause (Disease or injury SMALL BOWEL OBSTRUCTION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Jse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2X No 9 Unknown the þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes XX No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1XXNatural 5 Pending nours after death.

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filled in by the fu М 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Division of Vital Records, P.O. Box 68760 To the Hosp within 24 ho To the Fune completely f

29c. License number **D0032247** 7.21.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 1500 FOREST GLEN RD., SILVER SPRING, MD NOOSHIN FARR, M.D.,

29d. Date signed (Month, Day, Year)

State

29b. Signature and title of certifier

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 22 Day 201 2 Carmel Wilev 5:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 208 WINDWARD DRIVE WORCHESTER APT.A OCEAN CITY Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X**□ F Min. Hours JULY 15, 1936 Director 212-34-1232 PENNSYLVANIA 76 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. WORCHESTER OCEAN CITY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 WINDWARD DRIVE APT.A 21842 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3X Widowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OPERATING ROOM NURSE HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CARMINE COLANDER LEONA VOGLINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH WILEY SON PHOENIX, 4 MOLLIE COURT MD. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 7-28-2012 GLEN BURNIE, MD. 4 Donation 5 Other (Specify) SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service Licenses 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death Month Year signed by the a 9 Unknown q Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has performed? Yes 2 Divid 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Cortifue Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Madical scaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Catifying Warse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of ertifie 29d. Date signed (Month, Day, Year) 23 175046

Registrar

100 E Carroll

21861

W

SalBhus

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

myder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ JULY 24,20125:40 P. M MARY ELLEN WELLS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO. TOWSON GILCHRIST Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Days Director 1 M 2 XF 84 218-22-1528 9-8-1927 MARYLAND Usual Residence of Dece I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTO. NOTTINGHAM MD. 1 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 5143 TERRACE DRIVE 21236 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental H item 27 is marked of MARIE A. DOLEZAL JOHN J. SPANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUTHERVILLE, MD. 21093 PATRICIA CULOTTA SISTER 1309 BROADWAY ROAD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State 7-28-2012 BALTIMORE, MD. GARDENS OF FAITH 4 Donation 5 Other (Specify) MILLER-DIPPEL FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6415 BELAIR ROAD BALTO. MD. 21206 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ... List only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final troke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin hours after death. Ineral Director: After this certificate has been signed by the attending physician and ily filled in by the funeral director, page 2 should be detached for use as the burial-fran Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an 1 ☐ Yes 2 🗷 No ☐ Yes **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 1 X Yes 2 🗆 No hospice <u>ء</u>ِ| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural Accident 5 Pending М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely | Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2012 who completed cause of death (Item 23a) (Type, Print) ALVES M

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07 Physician/ 20°1′2 1:34 P Pearl Weeks Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Forest Hill Hart Heritage If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 91 **Director** 218-07-7326 1 M 2 St F 03/05/1921 MD Usual Residence of Dece 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Director Bel Air MD Harford 1 🗌 Yes 2 🛂 No 10g. Citizen of What Country? 10f. Zip Code by Funeral USA 613 Hickory Overlook Drive 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 8 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Janet Sepkowski Peter Bausch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important. If item 27 is
any injury or other trau 613 Hickory Overlook Dr., Bel Air, MD 21014 Gary D. Weeks - Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory of XXBurial 2 Cremation 3 Removal from State Highview Mem'l Gardens 7/26/2012 Fallston, MD 4 Doppation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signa / e of Funeral Service Licy isee 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Ran 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DeMentra STAGE Physician/ END disease or condition resulting in death) R Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter United Injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year fo Month Day 5 Other (specify) Pregnant at time of death signed by the a lid be detached f g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been signated by should be 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ate has b 1 ☐ Yes 2 ☑ No Funeral Director: After this certificate stely filled in by the funeral director, pag USISKO 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence CARE 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 39889 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) Bel AIR MA W. MACPITA.1 5 PARTUS 615 LARKI 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

12-05527 William Yarbough Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 23892

illiaiii Taiboug		1- For State Criticate of Death Registrar	Reg. No.	
Physicia	ın/	1. Decedent's Name (First, Middle, Last)	Date of Death Month Day	3. Time of Death
edical Exami	ner	William Yarbough	July 24, 2012	0519 hrs
		4a. Facility Name (if not institution, give street and number) Sinai Hospital 4b. City, Town, or Location of Baltimore	Death 14c. Co	punty of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24Hrs. 8 Date of Birth(MM/DD/	YYYY) 9. Birthplace (State or
Director		345-68-5491 1 M 2 F 124 Yrs. Months Days Hours	Min. Sent 72 Kg	Foreign Country) \(\lambda \lambda \)
	- 1	Usual Residence of Decedent	(Gept. 2), 11	771 700
' any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
and f shov	5	MD NA Baltimore		1 Ves 2 No
Mary r 28a- ed at	rec	10e. Street and Number	10g. Citizen	of What Country?
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ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kir during most of working life. DO NOT us		of Business/Industry
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MD td 2 shoulth and ulth and m 27 is		Minnie O. Yarbuugh 2930 Edgeco		Bakhmore, MD
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene at the fire 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must he notified at once,		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory) or other place)	Date 20c. Loca	ation - City or Town, State
드트 등 를 하		4 Dogation 5 Other Specify. 1 METVO	7/27/2012 E	a Himou, My
Balt permit. Departi Importinjury		21. Signature of Funeral Senet Licansee 22. Name and Address of Facility	Howell F	usual toxe
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care	dac or respiratory arrest, shock,	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease		Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):		
724 	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
<i>\</i>	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.		
led nsit	Exa	events resulting in death) Last Due to (or as a consequence of): d.		
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Box 687 death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic p	eregnancy Mo	nth Day Year
SOX Jeath e atter	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time or death 5 Other (Specify) 9 Unknown		
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Recc The lavicate hapage 2	E		performed? 1 Yes 2 ✔ No	death? 1 Yes 2 No
Vital Fysician: Sysician: Shis certific director, p	Be C	25. Was case referred to medical examiner?	heck only one)	
Physic r this	2	1 Yes 2 No Inspired 1 Inpatient 2 ER/Outpatient 3 DOA	Nursing Home 5 Residence	
Division of Vital Records, rate or Attending Physician: The law required in Directora. After this certificate has been seed in by the funeral director, page 2 should	on:	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Ves 2 N		occured
Atter Atter or deat rector by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Number or Rural Route Number, City
Div ital or its after its Div	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)	
Division of Vital To the Hopital or Attending Physician: within 24 hours alt or detending Physician: To the Funeral Director: After this certif completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only)	e, and due to the cause(s) and m	anner as stated.
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.		
	Σ	29b. Signature and title of certifier 29c. License number		e signed (Month, Day, Year)
1.00		Pata - Collehan O.C.M.E.	July 22	4, 2012
Com		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Stre 	et. Baltimore. MD 21223	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Regis		JUL 2 7 2012 June A. Soule		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Librada Arrieta 20Î2 July Рм 1:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 8802 Bolero Court Clinton 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 577-76-5514 Director 1 M 2 X F 87 10/29/1924 Phillipines or 28a-f shov should be filed within 72 hours after death with the Maryland I and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MDClinton Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 8802 Bolero Court USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Asian 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paciencia Orbeta Hombrebueno Lope Suyo Ardines 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai once. Alexander A. Arrieta/Son 8802 Bolero Court, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 07/12/2012 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line shock, or hear failure. Immediate Cause (Final Ph si i n Cardiopolymonary disease or condition resulting in death) Medical **Examiner** duance Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Certifica Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

DHMH 17 Rev 06-2011

Registrar

29b. Signature and title of certifier

Mary Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800

Fishman,

JUL 11 2012

Reservoir Rd NW,

egistrar's Signatu

Washington, DC 20007

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For MEND#2, 23a per phy. State of Maryland / Department of Health and Mental Hygiene Registrar aaco Health Dept. CMH

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7/1/2012 Physician/ Month AM OLIVE 11:50 AMBROSINI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death hehab YUPTON ANUNDEL VOFTON 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Days Hours Min. 260-80-2092 England 78 Director Usual Residence of Decedent i item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 USA 2526 Vineyard Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Deveraux Thomas Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Vinevard Lane. Crofton, MD 21114 19a. Informant's Name/Relationship (Type, Print) 2509 Vineyard Lane, Angela M. Brennan / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other 1 X Burial 2 Cremation 3 Removal from State Arlington Nat'l Cem. 7/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA Beall Funeral Home of Funeral Service Licensee 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Couse (Final Onset and Death Physician/ Adenocarcinana of the Cecum (Bowel) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ADENO CARCINOMA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year ☐ Pregnant at time of death☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NBALANCE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Chromic ATVIAI 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 1 Yes 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 00062395

Registrar

State

30. Name and address of person who comp

ALFONSO

6934AVIATION BLUD SLITEB 6RM BURNE MD 21061

leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anderson 9:20 P M Medical July 04. 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4 Woodbent Drive Severna Park Anne Arundel 5. Social Security Number Funeral 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 114-03-9065 90 1 X M 2 □ F Yrs. New York Sept. 14,1921 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exartary must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 4 Woodbent Drive 21146 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S.

Armed Forces?

1

Yes 2 □ No

WW II

If Yes, Give

Year or Dates. Black, White, etc 1 ☐ Never Married 2 🕅 Married ፩ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health end Mental Hitem 27 is marked ot ၉ John Adolf Anderson Regina Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Anderson / Son 453 Maryleborn Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 0, permit. Page 1
Department of I
Important: If it
any injury or of 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate has Leen signed by the ettending physician and page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate le Hosphe... in 24 hours after deam. the Funeral Director: After this certificate the Funeral director, pe 1 Yes 2 🗖 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending Division work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifie 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Se State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 9, Physician/ 2012 0538 AMMARY HELEN ANDREWS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 💢 F 7-18-1934 77 DELAWARE **Director** 222-22-5994 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10d, Inside City Limits Director 1X Yes 2 ☐ No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 19975 U.S. APT49 49 SHADY GROVE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE er than "natural", the Medical Exa Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FOOD SERVICE COOK permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ EARL W. LOVELAND MYRTLE S. CALLAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28111 GRAVEL HILL RD, MILLSBORO, DE. 19966 SCOTT ANDREWS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
MELSON'S CREMATORY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 7-10-2012 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD THATCHER ST, FRANKFORD, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events to (or as a nonvequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed erten attending physician and for use as the burial-tran as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Apneo 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 No Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No s after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BA4

State

Registrar

31. Date filed (Month, Day, Year)

11

Creek

ines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 6 M Owen F. Arnold 012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegani umberland Western Maryland Health System If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Director 212-10-9269 1 🛛 M 2 □ F 96 April 17,1916 PA Usual Residence of Decede or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Frostburg MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r Funeral 21532 USA 92 Pocahontas Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other tt Coal Miner 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Fred F. Arnold Annie Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important If item 27 is any injury or other trau MD 21532 92Pocahontas Rd., Frostburg, Mildred Milcetich, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) Greenvile Union Ceme. 07/11/2012 Meyersdale, PA 22. Name and Address of Facility W.R. Price Funeral Home, Inc. 21. Signature of Funeral Service Lice CC0376 325 Main St., Meyersdale, PA 15552 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final meumona Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2- No Hospital Other: 1 Yes ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death

Natural

Accident

Suicide

Homicide 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of g 1)0033280 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Gupta,625 Kent Ave., Suite 101, Cumberland, MD 21502 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Beckman Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegan umberla ハd Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oct 73, 1933 Director 220-28-9501 1 🗆 M 2 🔀 Country)MD 78 Usual Residence of Decede 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Spring Gap 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral P.O. Box 172 21560 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces 1 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates Completed Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Balco Manufacturing Co. clerical worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Piper Kirk Robey 19a. Informant's Name/Relationship (Type, Print) Leigh Beckman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Spring Gap vn, State, Zip Code) 3D MD 21560 daughte 20a. Method of Disposition
1 ☐ Burial 2 ☐ Vermation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 7/17/2012 MD 4 ☐ Denation 5 ☐ Other (Specify) Cresaptown gnatur 22. Name and carpellif Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ acuto remal disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year signed by the aid be detached for Pregnant at time of death Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ hyportension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No injury 24 hours after death. Funeral Director: A 2 Accident filled in by the Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar = MD

LIU M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2501

Willowbrook

072514

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Howard Brown, Sr. 2012 4:46 A Medical Julv 04 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Tate Chesapeake Hospice House Linthicum If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 98 Director 212-03-9672 1 X M 2 □ F April 11,1914 Maryland Usual Residence of Decedent or than "natural", or items 23e or 28e-f show the Madical Examiner must be mutified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Bellemeade Drive 21146 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceder Lvs.
Armed Forces?
1 Yes 2 No 14 Race - American Indian nit. Page 1 and 2 should be filad within 72 hours after or artment of Health and Mantal Hygiene.
ortant: If item 27 is marked other than "natural", or in injury or other treumetic event, the Marker Examin Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Koppers Company/ Elementary/Secondary (0-12) College (1-4 or 5+) Steam Hammer Operator Metal Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred William Brown permit. Page 1 and 2 should be Dapartment of Health and Mani Important: If item 27 is marke any injury or other treumetic to Emma Martha Stencil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon H. Brown / Son 104 Laird Benton Road Stevensville, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park July 09 Elkridge, MD 2012 21. Signature of Funeral Septice License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) tha attending physician and shad for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Day pega 2 should be datachad 9 Unknown 9 Unknown Division of Vital Records, P.O. ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown paen Were autopsy findings available prior to completion of cause of death? 24a. Was an After this cartificate has autopsy performed? 1 ☐ Yes 2 ☑ No within 24 hours aftar death.

To the Funaral Director: After this cartified complataly filled in by the funaral diractor, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) ၉ 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 1 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G929 7/27/2012 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Betty Louise Bowser Medical July 4:20 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Oakland Garrett Hospita Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F 5/25/1936 Director 215-36-8730 Maryland 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Garrett MD McHenry 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 699 Limousin Ridge Road 21541 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. Completed by 1 Never Married 2 X Married "natural", If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department Store 12 Supervisor Be 17. Father's Name (First, Middle, Last) and Mental His marked of 18, Mother's Name (First, Middle, Maiden Surname) Wilburn Randall Charlotte Kaiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Harry #: 699 Limousin Ridge RD., McHenry, MD 21541 Bowser/ Husband Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Deepete) remains or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baptist Cemetery 7/9/12 McHenry, Maryland Signature of Funeral Service License 22. Name and Address of Facility Newman Funeral Homes, P.A. 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that cause 1 the neath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final eset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2-No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred s after dea.
**al Director: After hy the firestore. 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined e Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Hospital or Attending Physician: The completed filled in by within 2 To the F

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

29b. Signature and title of certifier

Thomas
31. Date filed (Month, Day, Year) Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson MD

DHMH 17 Rev 7/2009

ORIGINAL

2. Registrar's Signature

29c. License number

311 N. Fourth Street, Oakland,

DOZ

29d. Date signed (Month, Day, Year)

MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clifton Bateson Don July 1, 2012 5:45 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 435 Vine St. Westernport Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 8 1929 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 213-24-6910 Months Days Hours **Director** 83 1 M 2 □ F Jan. Maryland should be filed within 72 nous and and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show armatic event, it a Medical Exemiter must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westernport MD Allegany 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 435 Vine 21562 St. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. ≥ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give KC Baltimore, Maryland 21215-0036 ır Yes, Give Year or Dates. white 1 ☐ Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Paper Manufacturer 12 Quality Control Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Don Bateson Eula Bateson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Bateson/ wife f Health 435 Vine St, Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: if it
any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other Philos Cemetery 07/04/2012 Westernport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wa 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final lasteti Onset and Death Physician Mo disease or condition ANGHOCARCINOMA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami ettending physiclan and for use es the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Year sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate rs after deau... rai Director: After this cer..... 2 🗌 No 1 Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner Hospital Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 🗌 Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)4255 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Gregg Donaldson, 912 Seton Drive, Cumberland, MD 21502 31. Date filed (Month, Day, Year) State 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended#25serMor FCHDaKS / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES RICHARD BODMER JUNE 2012 4:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 214-42-4954 1 **M** M 2 □ F 69 **Director** 12/18/1942 MD iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No FREDERICK IJAMSVILLE MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 3692 RIDGEVIEW ROAD 21754 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates Specify: WHITE 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working NATIONAL NAVY life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL SUPERINTENDENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ CHARLES WESLEY BODMER VIRGIE GERTRUDE HOWSER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21754 19a. Informant's Name/Relationship (Type, Print) MILDRED LOUISE BODMER/SPOUSE 3692 RIDGEVIEW RD., IJAMSVILLE, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN CEMETERY 6/28/2012 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ LHEMIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Pregnant at time of death Day signed by the at Id be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ WITH 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law 124 hours after death.

Funeral Director: After this certificate has letely filled in by the funeral director, page 2.8 autopsy 1 Tes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XX es 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar

5

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORID

MD

D70022

400 W 7th STREET.

23

MD 21701

FREDERICK,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 0530R M Monte Joe Bradley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Wicomico feninsula Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) ocial Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1 🖾 M 2 🗆 F 466-40-1741 05 | 16 | 1933 Texas Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 603 Belvedere Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black White etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Director of Food Services 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Salisbury State College 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any lijury or other traumatic. any lijury or other traumatic. Naomi Canafax Montrose Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Belvedere Terrace, Salisbury, Maryland 21804 Nagla Bradley|wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 07 | 10 | 2012 Parker County, Texas Newberry Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee HOLLOWAY Funeral Home P.A. aris H Dompor CFSP 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEP515 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MAITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death Dav Year been signed by the a should be detached 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salishum MD 21801 140 31. Date filed (Month, Day, Year) 32. registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23905 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{™7}-04-2012 Norvalee Virginia Broyhill 7:19 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Hours (Month, Day, Year) Director 1 □ M 2 🖁 F 228-24-2390 Yrs. 86 11 11 1925 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland ir then "neturel", or items 23e or 28e-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Salisbury 1 X Yes 2 ☐ No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1105 S. Schumaker Drive Apt. 309 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) no Mental F ပ permit. Page 1 and 2 should be Department of Health and Meni Importent: If Item 27 is marke eny Injury or other treumatic once. Milton Garnet Smith Maude Barron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Schumaker Dr., Apt. 309, Salisbury, MD 21804 John Broyhill|husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Salisbury Crematory 07 05 2012 Salisbury, Maryland 21. Signatur of Funeral Service cense 22 Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd., Sailsbu Sailsbury, Maryland 21804 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ca Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician end I for use as the buriel-transit the Hospital or Attending Physicien: The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Day Year n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death2 this certificate has been signal this think the think the sector, page 2 should the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 12 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Cify or Town, State within 24 hours aft To the Funerel Dis completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 31. Date filed (State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vear Jume 30, 2012 17:02 George G. Betz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fruitland Wicomico 27105 Walnut Tree Rd. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days (Month, Day, Year) Director 216-30-6779 1 X M 2 - F June 10, 1935 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f sho any injury or other treumatic event, If the M. Jic. Lexaminer must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland | Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21826 27105 Walnut Tree Rd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mary Tinker George F. Betz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ben Betz Son 8268 Gumboro Rd., Pittsville, Maryland 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 7-5-2012 Salisbury, Maryland 22. Name and Address of Facility
Holloway Funeral Ho
501 Snow Hill Rd., 21. Signature of Funeral Service Scensee Home P.A. , Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death andionyop Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque ce if): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.
Funerel Director: After this certificate hetely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2/ No Certificate: To 1 Inpatient 2/ ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi The defice of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053394 2013 m properson who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Box 68760

Records, P.O.

Division of Vital

0 6 2012

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year 5:08 P Physician/ Herbert Joseph Berger 0 2012 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner nmi If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex 1X☐M2☐F DEountry) Months Hours Min 1 2-5-1 930 81 Director 579-36-3197 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Parsonsburg MD Wicomico 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral USA 7861 Crofton Drive 21849 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Angred Forces Black. White, etc. All Yes 2 No
If Yes, Give Navy
Year or Date Reserve þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: speWhite "natural", Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event the proce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Peter Berger Margaret Desel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2070512325 Old Gunpowder Rd Spur, Beltsville, MD Lisa Berger-Acuna/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Communication) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Cremation, 7-9-2012 4 Donation 5 Other (Specify) birect Dover, DE 22 Name and Address of Facility 917 W. Bennie Smith Ignature of uneral Service Licensee Isabella St. Home Salisbury, Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death LUNG CARCINOUS Physicians) MALIGNAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine day, leading to ministrate cause. Enter Underlying Cause (Disease or linjury that initiated events Disects for as a consection of the attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate t completed filled in by the funeral director, page 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending work 2 No 1 Yes Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a Heway L 31. Date filed (Month, Day, Year)

10

12-04876 Dennis L. Bumpas		Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and Certificate of Death		ene	201	2 239
Physiciar Medical Examín	1/	1. Decedent's Name (First, Middle,Last) Dennis L. Bumpass		Reg. I ate of Death onth Da ne 29, 201	10.	3. Time of Death
Medical Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L 8001 Lake Crest Drive #102 Greenbelt		ne 29, 201	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 242-06-3491 Months Days	Lieuwe Min	Date of Birth (N	//M/DD/YYYY) 9. Bir	
м ану	ŀ	Usual Residence of Decedent 10a. State Maryland 10b. County Maryland 10c. City, Town or Location Greenbelt		723/15	01 00	10d. Inside City Limits
ne Maryland or 28a-f show any lied at once.	9010	10e. Street and Number 10f. Zip Code 8001 Lakecrest Drive Apt.#102 20770		_	Citizen of What Cour	1 Yes 2 No
r death with the	- L	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 No	Mexican, Puerto Rican		White, etc.	can Indian, Black,
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene. If I titen 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at once.	Completed by	3 Widowed 4 Divorced If Yes, Giva Year 1980-2000 1 Yes 2 No 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Corresponding Secondary Secon	on (Give kind of work d DO NOT use retired)	Sı	Specify: Bla b. Kind of Business/I mall Busin dministra	ness
215-003 be filed within that Hygiene. rked other the ent, the Med	mon ea		8.Mother's Name (First		len Surname)	
MD 21 d 2 should I fth and Mer n 27 is man numatic ev	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Street and Street) Carolyn Cook (Sister) 6508 Quentin Cook	ourt New C	arroll	ton, Mary	land 20784
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importmett of Health and Mental Hygiene. Importmett. If tiem 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Sgnature of Funeral Service Censee 20b. Place of Disposition (Name of ceme crematory or other place) Maryland Vet. Ceme 22. Name and Address of Service Censee	tery 7/11/	2012 C		, Maryland
Physician /Medical	+	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su failure. List only one cause on each line.	reet, N.W. uch as cardiac or respi	Washi	ngton, D.	
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xecuted n and I - transit	= L	events resulting in death) Last Due to (or as a consequence of): d UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transical Certification: To Bo Completed by the Directional Experience of the contraction of the contractio	Iysiciari/medi	F FEMALE: 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of delivery Month D	yay Year
Division of Vital Records, P.O. B tal or attending Physiciae: The law requires that the d its after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached the cast of the page 2 should be detached the page 2.	3	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv		1 Y es 2 24a. Was an	24b. Were au	ably 4 Unknown
Vital Records, I ysiciao: The law requires inis certificate has been significate, page 2 should be Commission.		25. Was case referred to medical 26.Place o	of Death (Check only or			ompletion of cause of
f Vital Physiciae Physiciae er this certi			ther Nursing Hom	ne 5 Res	idence 6 🗹 Other	Scene
Division of Spital or Attending Phours after death. meral Director: After to filled in by the funeral	IIICATION.	(Month, Day, Year)	es 2 No No Idding, etc. 28f. L		et and Number or Rui	ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	e and place, and due to	the cause(s)	and manner as state	
To the Howithin 24 For the Function Completely	DOM	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated. 29b. Signature and title of certifier O.C.M.	number	29	place, and due to the d. Date signed (Monume 30, 2012	
100	;	30. Name and address of person who completed cause of death (Item 23a)	more MD 21222			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month, Day, Year) istrar JUL 1 2012

32. Registrars Signature

			Ple 1 _ For State			nd / Depa	artme	nt of H	lealth		•		_		2 2	200	
	Physicia		Registrar 1. Decedent's Name (First, Midd		rene Bo		titica	te of E)eath			aath	0.		3. Time o		
	Medi Examir		1 5 22 11 22					, Town, or 1ktor	Location	of Death	4c. County of Death Cecil 8. Date of Birth SEPT 177, Year 923 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
	Funeral Director		5. Social Security Number 218-18-8583 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 88	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours				923	9. Birthr Coun Ma	olace (State of try) ryland	or Foreign	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	10a. State 10b. County Maryland Cec 10e. Street and Number 514 North Street 11. Marital Status 11. Marital Status	eet	dent Ever in U.	ty, Town or Lo Elkton S. 13. \	10f. Z	ip Code 2192]		igin? (Spec	cify Yes or No	I	Unite	What Cour ed St e - Americ	1 X Yes ntry? ates an Indian,		
21215-0036	n 72 hours after e. s. an "natural", or Medical Examii	Completed by		rried 1 Yes	2 X No e ites.	16a. Deced	1 ☐ Yes	2 X No	Specify.				Specify:	Whit	e	- 1	
Maryland 213	d be filed withi Mental Hygiene arked other th atic event, the	To Be Co	11 17. Father's Name (First, Middle, James Casho R:	Last)		Но	mema	ker		er's Name	, ,	, Maiden			wn Hon	ie	
	and 2 should Heaith and M tem 27 is mar ther traumat		19a. Informant's Name/Relations Donna M. Gipso 20a. Method of Disposition	on/Daughte	20h	514	Nort	h Sti	eet,	E1kt	on, MI	2.	1921				
Baltimore,	permit. Page Department o Important: If any injury or once.		1 🛣 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 21. Signat re of Funeral Service	(Specify)	State Gi.		2. Name a	nd Addres	s of Facili	2012 ty Hic	ks Hom	ne fo	E1kto	on, M	D ls, P.	Α.	
	Priyoician/ Medical Examiner unial-transit	al Examiner	23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Due to (uence of):	er the mo	de of dyin	g, such as						Approximat Interval Bet	ween	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. Of the Fusehal Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, out	come of pregna Birth 2 Fet nant at time of	ancy al death 3		pregnanc							,	Year	
ds, P.O.	requires that the de been signed by the should be detached	Completed by	by	Part II. Other significant condit	ions contributing to de	eath but not res	sulting in the u	ınderlying	cause giv	en in Part	l.			x1			
I Reco	n: The law re ficate has be or, page 2 sh		25. Was case referred to medical 26. Place of Dec							ath (Check	auto perf 1 🗆 Yes	DSV	l p	rior to co leath?	mpletion of c	available ause of	
Division of Vital Records,	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page	Certificate: To Be	3 🔲 Suicide 6 🗀 Could	ing 28a. Date (Monting igation I not be 28a. Place	Inpatient 2 Confinition of Injury - At he	28b. Time of injury	М	OOA Othe 28c. Injury work 1 \square	er: 4 🗆 No	ursing Hon 2 No	ne 5 Resi	how inju	ry occurre	ed		ner	
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical Cer	(Check 2 Medical	g Physician: To the be Examiner: On the bas	ng, etc. (Specification) est of my known is of examination	vledge, death on and/or invest	occured a	t the time,	n, death o	place, and	due to the ca	use(s) a	e) and manne e, and due	er as state	d. use(s) and ma		
•	To the withing the complete co	4	29b. Signature and title of certific	Han H	D		29	c. License		3							
	Sta Registr		30. Name and address of person JUI Chih 31. Date filed (Month, Day, Year)	HSU P	e of death (Iten	223	NU	はイ	ian	et,	Elleta	nll	1d	2	921		

12-05270 Michael Buchanan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 23910

	Registrar	e of Death	Reg. No.	
Physician/ Medical Examine	Decedent's Name (First, Middle,Last) MICHAEL BUCHANAN	l N	Date of Death Month Day Year July 13, 2012	3. Time of Death 1017 hrs
ن	4a. Facility Name (if not institution, give street and number) 465 W. South Street	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 116-58-5149 70		Date of Birth(MM/DD/YYYY) 9. Bir 4/27/1952 Foreig Co	
taryland 186 - Fabow any 186 once. OCTOR	Usual Residence of Decedent 10a. State			10d. Inside City Limits
death with the Maryland or items 23a or 28a-f sho must be notified at once-unertal Director	10e. Street and Number 465 W. SOUTH STREET	10f. Zip Code 21701	10g. Citizen of What Coul	ntry?
e	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Dates:	3. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 1 Yes 2 XX No specify: 1 Susual Occupation (Give kind of work)	n, etc.) White, etc. Specify:	white
215-0036 he filed within 72 hours a mall Hygiene. rked other than "matural ent, the Medical Examin Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) R E	ng most of working life. DO NOT use retired) SIDENTIAL	CONSTRUCT	•
21215-0036 Metal Hygiene. marked other than marked other than cervent, the Medica.	17. Father's Name (First, Middle, Last) ALVIE BUCHANAN 19a. Informant's Name/Relationship (Type, Print) 19b. M	MARY AN	ot, Middle, Maider, Surname) NE SPRINKLE	
M 2 alth alth 2 m 2	SHERRI BUCHANAN/SISTER 10	lailing Address (Street and Number or Rural 1709 CARLYLE STREET, 1 (sposition (Name of cemetery, 1 Date	WILLIAMSPORT, MD	21795
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the	1 Burial 2XX Cremation 3 Removal from State SMITHSBU	isposition (Name of cemetery, or other place) RG CREMATORY JULY 1: 201:	8, SMITHSBUD	,
	Robert C. Geld	327 W. KING ST., MARTINS		
Physician /Medical Æxaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line. Immediate Cause (Final disease a. Alcohol and Morphi		oiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			
ored d ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit		per me,g930 8-1-12 s	sm.	
). Box 68760, the death certificate by the attending physiched for use as the burn Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 22c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month D	ay Year
F.O. E ires that the signed by the detached by the detached by the detached by the by the by Ph	Part il. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Records The law requicate has been page 2 should			autopsy prior to c death? ✓ Yes 2 No 1 ✓ Yes	topsy findings available ompletion of cause of
Vital ysician: his certifi director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpar	26.Place of Death (Check only contient 3 DOA Other Nursing Hor		Scene
ion of Vi teoding Physi eath. for: After this the funeral dir	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time		Describe how injury occurred	-
Division o To the Rospital or Atteoding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune- ledical Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) Singla Far	street, factory, office building, etc. 28f.	Location (Street and Number or Rul or Town, State 465 W. Sou ederick, MD.	al Route Number, City th St.
To the Host within 24 ho To the Fund completely f	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investant manner stated.	occurred at the time, date and place, and due t	to the cause(s) and manner as state	
H % H %	29b. Signature and title of certifier Yumuli Rotthary, Mi)	29c. License number O.C.M.E.	29d. Date signed (Mon	th, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MDAssistant Medical Examiner	900 W. Baltimore Street, Baltimore	e, MD 21223	
State	31. Date filed (Month, pay, YGz) 32. Segistrar's Signature	barker		·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nettie Cano July 8, 2012 10:23 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Mitchellville Prince George's 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) 577-62-6559 **Director** 1 M 2 X F 81 Feb. 13, 1931 Cuba ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Prince George's Bowie N☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2705 Barberry Lane 20715 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Cuban Completed If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Bank Clerk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Silverio Baranda Maria Teresa Basallo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damaso Michael Cano/spouse 2705 Barberry Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Decremation 3 Removal from State cemetery, crematory or other place, Metfo 7-10-2012 Donation 5 Other (Specify) Crematory Baltimore, MD 1. Signa ure of Fure al Service Licen. 22. Name and Address of Facility Peall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day 9 Unknown After this certificate has been signed by a funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 ☐ Yes 2 🗹 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geatin occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 20064852 ONCOLUGY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANG State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Cross 6:39 A M Leonard Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 1003 Elkhart Street Oxon Hill 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days 01/12/1915 577-09-0550 97 Director XX M 2 D F Washington, DC Yrs th end Mentel Hygiene. 27 is marked other then "naturel", or items 23e or 28e-f ehow treumetic event, the Medical Exemplant results and the matter 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's 1 Yes 2 XXIVo Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1003 Elkhart Street 20745 USA 72 hours efter deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW 1 ☐ Yes 2 KNNo Specify: White Specify: Completed 3XWidowed 4 ☐ Divorced II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Supreme Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Walter Cross Ada Ε. Crook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Depertment of Health er importent: if item 27 is eny injury or other treu Linda S. Lauziere / Daughter 3245 Captain Demont Dr. Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 X remation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/13/2012 Kalas Crematory Edgewater, Maryland 21. Signature of Financial Service Lious 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours efter death.

Ye the Funeral Director: After this certificete has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death g 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 🗆 Yes 2 🗖 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Date filed (Month, Day, Year)

State

Registrar

JUL 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:05 AM Philip J. Crossfield 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Silver Spring Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Country)
1915 Washington, DC 1 ☑ M 2 ☐ F **Director** 215-44-3470 96 October 7 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 X Yes 2 No Ма Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20904 3128 Gracefield Rd #HS 115 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 lith and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) NASA Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elberta A. Thom Philip Crossfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Silver Spring, Md 20904 3128 Gracefield Rd #HS 115 Alline R. Crossfield / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory: 6/28/12 Brentwood, Md 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**X** No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 4 Mursing Home 5 Residence 6 Other (Specify) ၉ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 No 1 Yes Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D24093 6/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20904 3110 Gracefield Rd Silver Spring, Md Mark Parkhurst, M.D. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 3 2012 Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O6 Physician/ Rufus Cross Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicam If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 218-50-1131 Director 1 🛣 M 2 🗆 F 1-7-1945 GA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 208 Anthony Lane 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Specify lack 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, Maryland 212 Green Giant Co. Production Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Cross Dora Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin Cross/Brother 10903 Potomac St, Glendale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) LC 20c. Location - City or Town, State ☐ Burial 2 【 Cremation 3 ☐ Removal from State Direct Cremation, 7-12-2012 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 21. Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinone Physician/ lary-geal disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and I for use as the bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 ☐ Yes 2√ C/No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Hospine 4 ☐ Nursing Home 5 ☐ Residence & Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: **Hospital or Attending** Natural 5 Pending Work: 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 U Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06399 of person who completed cause of death (Item 23a) (Type, Print) SALISBULY, MD VOHRA 910 EASTERN SHORE DR. 31. Date filed (Month, Day, Year) State 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 26 Day 201 Zear Physician/ 11:47а м Roxie L. Cottman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Gilchrist Hospice Care, Inc. Howard 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Hours 213-22-8798 **Director** 1 🗆 M 2 🕱 F 11-8-1922 MD 89 show 10b. County 10c. City, Town or Location 10d. Inside City Limits at should be filed within 72 hours after death with the Maryland Director items 23a or 28a-f s er must be notified 1 Yes 2 X No Columbia Howard 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 4802 Teal Wing Ct, Apt 101 21045 USA "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Sped lack 3 XWidowed 4 ☐ Divorced other than "nature rent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 12 Home Health Aide Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edgar Trader Margaret J. Nairne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8108 Felbrigg Hall Rd, Glendale, MD 20769 Renee Pedro 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-6-2012 Hebron, MD Spring Hill Cem 22. Name and Address of Facility 917 W. Bennie Smith Isabella St. Six nature of Euveral Service Licensee Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RENAL DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a cons-o ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsv Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🗷 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 1 🔀 Natural iniury 5 Pending s after death.

I Director; Afted in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n. ..n 24 hour. .e Funeral Dir. .v filled in bv determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D64395 TUNE 26,2012 310 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD 6336 CEBAR LANE COULMBIA, MD 21044 DANIEUE DOBERMAN, 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 23916 12-04964 William Alfred Cole, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 2, 2012 Medical Examiner William Alfred Cole 1420 hrs Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 502 West Main Street Salisbury Wicomico 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 214-34-8029 1 X M 2 F 72 06/01/1940 Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits RIII 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 X Yes 2 No items 23a or 28a-f shoust be notified at once. Maryland Wicomico death with the Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 706 Richmond Ave. 21801 USA Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes Black 1 Yes 2 No specify: 3 Widowed 4 Divorced f Yes, Give Year or Dates: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "n or other traumatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 10 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William A. Cole Sr. Alice Johnson 19a. Informant's Name/Relationship (Type, Print) ဥ Nancy Cole / Wife 706 Richmond Ave., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Buria! 2 Cremation 3 Removal from State Department c Salisbury Crematory 7/10/2012 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee LIN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Medical a Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury, MD ZIOUI 120c. Location - City or Town, State Salisbury, MD 22. Name and Address of Facility
Stewart Funeral Home by Holloway and Downey, P. A Approximate Interval Between Onset and Death Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED 23a, 27, 28a-f, per me, g931 9-28-12 sm X UNPENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene ၉ 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No subject drowned self 5 Pending 7-2-12 fd 1415 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 502 West Main St. Salisbury, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be Fd: Wicomico River determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed Box 68760, Records, P.O. the Hospital or Attending Physician: Division of Vital thin 24 hours after death.

the Funeral Director: Ampletely filled in by the ft.

and

attending physician or use as the burial -

has been s

this

After the funeral

State Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD.

31. Date filed (Month, Day, Year) 2012

O.C.M.E

July 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Priscilla Vincent Collier 201^{Yea} July 12:55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 104 Mapleton Street Hurlock Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Davs (Month, Day, Hours Min. **Director** 026-26-0038 81 ľ931 Massachusetts Usual Residence of Decedent 28a-f shov 10a State 10h County 10c. City, Town or Location Director 10d. Inside City Limits be notified Maryland Dorchester Hurlock 1 X Yes 2 No 'n 10e. Street and Number death with the 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 104 Mapleton Street 21643 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS "natural", or iter Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) State College (1-4 or 5+) 11 Case Worker Government Be 17. Father's Name (First, Middle, Last) h and Mental H 18. Mother's Name (First, Middle, Maiden Surname) 2 should be Jared Lambert Vincent Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Ada Greenwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde F. Collier, Jr./Husband Page 1 and 2 P. O. Box 247, Hurlock, Maryland 21643 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Veterans Cemetery 4 Donation 5 Other (Specify) MD 7/13/2012 Beulah, Maryland Name and Address of Facility Siller Funeral Home, P. O. Box 207 Main Street, East New Market, MD 21631 22. Nar **Ze 1** 106 Pp. 1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 No certificate 2 No 1 🗌 Yes After this certification funeral director, p Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural injury 5 Pending within 24 hours after death.

To the Funeral Director, Af Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number

State Registrar 30, Name and address q

Zust nt / Ut

NEWMIES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 1427 PM CANTER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death CENTER UNIVERSITY OF MARMIAND MEDICAL BALTIMORE S. GLEENE STREET Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9-70-8700 Director 1 M 2 D F Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director albut 1 Yes 2 No rap 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral SA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working d 2 should be filed within 72 alth and Mental Hygiene. 27 is marked other than "I traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Treatment reatment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carter 0 Mes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or Mar ra Maryland 21673 rive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Paradise 12 Cemetery Trappe, Mary land 4 Donation 5 Other (Specify) Name and Address of Facility Signature of Funeral Service Licenses Home, Henry MD.2/6/3 washington 23a. Part 1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ACIDOSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: has autopsy performe certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only ope Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and

31. Date filed (Month

le of certifie

GREENE

UNNE

2012

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

ess of person who completed cause of death (Item 23a) (Type, Print)

LOMON, UNIVERSITY OF WARYLAND MEDICAL CENTER

BVE ST, BALTIMORE, MD 21201

Registrar's Signatu

29c. License number

118

491370

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6:40 PM Physician/ 2012 Cameron samue Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Prince George's Hospita Laurel .dure If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. (Month, Day, Year) WEST PALM BEACH 135-24-0004 1**X** M 2 □ F 79 Director LO-19-1932 FT.ORTDA or 28a-f show 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD PG LAUREL 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral IIS 20707 13501 BELLE CHASSE BLVD., #SUITE or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No If Yes, Give X Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: er than "natural", the Medical Exar 3 Widowed 4 Divorced BLACK Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 ral Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PUBLIC SCHOOL ADMINISTRATOR PALM BEACH SCHOOL CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ ANDERSON CAMERON AUDREY THEUS 1 and 2 should by Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) REV. WINTHROP S. CAMERON/SON 5713 PLATA STREET, CLINTON, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
ARD UNIVERSITY
LEGE OF MEDICINE WASHINGTON, DC 4 X Donation 5 ☐ Other (Specify) 7-11-2012 POPE FUNERAL HOMES, P.A. 22. Name and Address of Facility of Funeral Service Licensee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 M01623 23a. Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Congestive Physician disease or condition resulting in death) Heart Medical Due to (or as a constollence of) Examiner Arrhythmia Escus della list excellions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autops, performed? Ves 2 No autopsy death? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No М Accident Investigation filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined after City or Town, State) To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 9247 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regional Hospita 20707 aurel Mohamed MD Tourky

State Registrar e filed (Month, Day, Year)
JUL 1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:32 AM 2012 James R. Courtney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SI BALTIMORE AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours 212-16-9447 **Director** 1 X M 2 □ F Yrs. June 20, 1916 MD 96 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1X Yes 2 ☐ No Catonsville Baltimore MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 21228 707 Maiden Choice Ln., Apt.9G09 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items
any injury or other traumatic event, the Medical Examiner mu
once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates. 1934–1968 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Major Marine Corps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mae G. Kirby Winfield H. Courtney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Windy Oak Ct., Crofton, MD 21114 Donna J. Courtney/Daughter 20b. Place of Disposition (Name of Mt. cem2et/, Ornat TA it lere (de) 20a. Method of Disposition 20c. Location - City or Town, State July 25, 1 X Burial 2 Cremation 3 Removal from State 2012 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery Freeland, MD ature of Funcial Sovice Lean 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. New Freedom PA 17349 24 N. Second St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Atheroscles ,Physician/ Covencry Vascula disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records. P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 3 Ectopic pregnancy Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tes 2 Ho this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျ 1 🗌 Yes 1 Inpatient 2 FER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 D50293 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr Hespital, BACTIMONE, concerna 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6

DHMH 17 Bev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 5. 2012 5:40 AM Dove Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park Severna Park Heartlands If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months **Director** 577-50-8426 1 🗆 M 2 🗶 F March 5. 1938 Washington, DC 74 Usual Residence of Decedent 10a. State 10c. City, Town or Location Director notified 28a-f 1 Yes 2 No Maryland | Calvert St. Leonard 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? 0 ems 23a or Funeral USA 20685 5940 Rebecca Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Albert Schultz Helen Marie Dolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5940 Rebecca Court St. Leonard, MD 20685 Joseph Dove/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 7/10/2012 | Clinton, MD 21. Signature of Pera 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Al 2heinen disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant 9 Unknown Pregnant at time of death ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has t director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined filled 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 00060120 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 nitchellville Rd #B-216 Bowie, ms 20716 # hmn Has 31. Date filed (Month, Day, Year 32. Pagistrar's Signature State JUL 09 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Vear Physician/ 8:30 Margarite 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MedStar Montgomery Medical Center Montgomery Olney 8. Date of Birth (Month, Day, Year) 11/23/1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 577-54-8877 **Director** 1 M 2 X F 72 Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland at Director notified Md Montgomery Silver Spring 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 23a c t be n 10g. Citizen of What Country? Funeral 3506 Peartree Court 20906 USA Examiner must 'natural", or items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Black 3 Widowed 4X Divorced Completed Year or Dates r than "nu. "ne Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than Elementary/Secondary (0-12) College (1-4 or 5+) Private Manager 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Rebecca Simpkins Tom Bennett traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Second Lock Rd Lancaster, Pa. 17603 item 27 Kim Stoltzfus Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 07/17/12 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Brentwood, Md 21. Signature of Funeral Service Licensee 2Shead Afrineral Home & Cremation Service 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Myecondial Acute disease or condition resulting in death) day Medical Due to (or as a conseque ce of) **Examiner** month Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of B Stage Kenal month To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 88 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Por Month Dav Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft
d in by the fur 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation Could not be 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Directory

completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar

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State

29b. Signature and title of certifier

Yuanine L. Zhana 31. Date filed (Month, Day, Year,

rred at the time, date and place, and due to the cause(s) and manner as stated.

D61624

29d. Date signed (Month, Day, Year)

2012

Certifying Nurse Practitioner: To the best of my knowledge, death occur

32. Registrar's Signature

Med Star Montgomery

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ John Joseph Darby, Jr. 11:15 Αм July Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5555 Friendship Blvd. Apt. 225 Chevy Chase Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 578-52-6884 73 1 2 M 2 D F **Director** 02/11/1939 Washington, DC 28a-f show Oa. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Montgomery Chevy Chase 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code o 10g. Citizen of What Country? 23a 5555 Friendship Blvd. Apt. 225 20815 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) event, the 4 Financial Consultant Finance other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental H ၉ John Joseph Darby Margaret Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 4400 Jenifer Street NW Apt. 2 Washington, DC 20016 Christopher Darby / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any Injury or o jo 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery | 07/13/2012 Washington, 22. Name and Address of Facility Joseph Gawler's Sons LLC. 21. Signature of Fundral S 5130 Wisconsin Avenue NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Parkinson's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a /Medical Division of Vital Records, P.O. Box 68760 the 35 attending IF FEMALE 23c. If yes, outcome of pregnancy use Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 9 Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The Hospital or Attending Physician; The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🔀 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

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State

7758 Wisconsin Ave. Suite 211 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy Fried MD

31. Date filed (Month, Day, Year)

D34590

July 10, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical RAYMOND LEROY DTCK Jul 2012 48 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospita] Frederick Frederick **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 212-50-5393 **Director** 1 **⊠**KM 2 □ F 65 Nov. 22, 1946 Maryland or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tifew 275 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? 21788 8515 Links Bridge Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces by 1 X Never Married 2 ☐ Married Yes 2 XXNo Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 K No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) disabled 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl Lee Dick Fleta Pauline Dick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8515 Links Bridge Rd., Thurmont, MD 21788 Barbara Dick / Sister-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July Tate, ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) permit. Page Department of Important: If any injury or once. Resthaven Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Fusion ervior Licensee Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody P.A. Frederick, MD 21701 23a. Part 1. Enter the disease, shock, or heart failure. Li , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Examiner PD 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events and resulting in death) Last Due to (or as a consequence of): as the burialattending physician Physician/Medical certificate be Box 68760 IF FEMALE: nse yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred o the Hospital or Attending 1 Natural 5 Pending injury Investigation
6 Could not be 1 Yes 2 No Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J-17 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West 7th Street, Frederick, MD 21701 Michael Lerner, M.D. Registrar's Signature State Registrar

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month)

32. Segistrar's Signature

LELAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Ruth Marie Davis Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death **Examiner** Dorche -ambridge 9. Birthplace (State or Foreign If Under 1 Year If Under 8. Date of Birth Security Number **Funeral** March I5, 1961 Months 1 M 2 X F Mary land 51 216-70-1440 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Cambridge 1 Yes 2 X No Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō er than "natural", or items 23a on the Medical Examiner must be USA Funeral 21613 2145 Horns Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S Armed Forces Black, White, etc. by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other tha own home homemaker traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ann Jarrell permit. Page 1 and 2 should be Department of Heaith and Ment Important: If item 27 is marke, any injury or other traumatic e once. Ronald Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21613 514 Greenwood Ave. Apt. 301, Cambridge, MD Amber J. Davis daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2X Cremation 3 Removal from State Crematory of Delmarva Delmar, DE 7/11/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee Cambridge, MD 700 Locust St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. 2 mon + 45 Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNO 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 1 Yes ပ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Mary S. DeShields

1 2 2012

31. Date filed (Month, Day, Year,

M.D.

Registrar's Signatur

509 Idlewild Ave., Easton, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mar	yland /	•			and M	ental Hy	giene		
			State Registrar			Cert	tificate of D	eath			Reg. No.	20	12 2392
	Physicia	n/	1. Decedent's Name (First, Middle, La							Date of Dea Menth	ath 8 Day	2012	3. Time of Death 8:00 а м
	Medic		Vernon A. Dim. 4a. Facility Name (if not institution, give				4b. City, Town, or	Location of	f Death			County of De	
ار .	Examin #	er	John B. Parso				Salish					icomi	
	Funeral				In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birl (Month, Da		9. E	Birthplace (State or Foreign Country)
	Director		212-20-0416 Usual Residence of Decedent	^{1 X M 2 □ F} 88		Yrs.				10-25-			**
	and show	ō	10a. State 10b. County	1	I0c. City, Tow	n or Loc	ation					•	10d. Inside City Limits
	Maryl 28a-f	Director	MD Balti	more	Glen	Arn	n						1 ☐ Yes 2 No
	h the		10e. Street and Number				10f. Zip Code					izen of What	Country?
	ms 2.	Funeral	4424 Langtry	Drive 12. Was Decedent Eve	ar in IIS	13 W	21057 /as Decedent of Hi	spanic Orig	in? (Spec	ify Yes or No-	USA		nerican Indian,
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. itam 27 is marked othar than "natural", or itams 23a or 28a-f show other traumatic avant, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No. If Yes, Give	0.0.	If	Yes, specify Cuba	n, Mexican,				Black, Wh	hite, etc.
8	hours nature	Completed	15. Decedent's		16a		ent's Usual Occupa		,		16b. K	ind of Busines	ss/Industry
2	iln 72 ie. han "i	E G	(Specify only highest of Elementary/Secondary (0-12)	College (1-4 or 5+)		life. DC	ind of work done of NOT use retired)		ot workin	g	D = =	l Dat	+
7	i be filed within 72 fental Hygiene. rked othar than " tic avant, the Me	Be C	17. Father's Name (First, Middle, Last	4	Ti	tle	Examine		ula Nama	(First, Middle,		al Est	Late
anc	be file ental F ked o c ava	일	Anthony Dimar							iccicl		Surriame)	
ary	should be and Ments 7 is marked raumatic a		19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street a	and Numbe	r or Rural	Route Numbe	r, City or	Town, State,	Zip Code)
Ž	nd 2 si saith a n 27 is		Jerry Coulson	/Stepson) Crave		ırt,	Sali	sbur	cy, MI	21801
Baltimore, Maryland 21215-0036	e 1 ar tof He Mritar or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐ Removal from State	20b. Place of cerneto	of Dispos ery, crem	sition (Name of patory or other place			ate		,	or Town, State
Ē	it. Pag rtmen rtant: njury		4 Donation 5 Other (Spec		birec	t C	remation			2012		er, I	
Bal	parmit. Page 1 a Dapartment of I Important: If its any injury or of		21. Signatur of Funeral Service Lice	. a. Rour	ds		Name and Address ennie Si uneral		Sal	isbur	y, N	4D 218	301
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.							rest,		Approximate Interval Between Onset and Death
ores f	mysician/ Medical	18	Immediate Cause (Final disease or condition resulting in death)	a	Mekas	itat	ic Blad Prostal	der	Can	eir			24 Cers
-	Examiner			Due to (or as a	consequence	: от):	Prostal	T Car	rus				
-		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to or as a									
	cuted	Examiner	Cause (Disease or injury that initiated events	c. Due to (or as a		- cn-							
0	be exe sician a burtal	dical	resulting in death) Last	Due to (or as a t	Consequence	oij.							
3760	ficate g phys as the	Jedi		- a									
Division of Vital Records, P.O. Box 687	To the Hospital or Attanding Physician: The law raquires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal dea		Ectopic pregnand Other (specify)	у				23d. Date of Month	delivery Day Year
P.0	that the	y P	Part II. Other significant conditions	contributing to death but	t not resulting	j in the u	nderlying cause give	ven in Part	l.	23e. Did 1	obacco u	use contribute	e to the cause of death?
ds,	quires en sig ould b	ted								1 🗆	Yes 2	₩ No 3 [Probably 4 Unknown
COL	law ra has be e 2 sh	nple								24a. Was		24b. Were prior death	autopsy findings available to completion of cause of
8	: The icate r, pag		25. Was case referred to medical							1 🗆 Yes		0 1 🗆	Yes 2 No
lital	siclar certif	o Be	examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 ER/0	D stration	Oth	ace of Dear		only one) me 5 ☐ Resi	donos 6	C Thoras (Se	pecify) JB Parson
€	g Phy er this neral c	을 일	27. Manner of Death	28a. Date of injury (Month, Day,	28b	Time of injury		y at	-	28d. Describe			Assisted i iven
O	andin eath. or: Aft the fur	ficat	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	ion	rear)	плогу		Yes 2 🗆	No				
Sivis	al or Att s after d I Direct d in by	Certificate:	4 Homicide determine			farm, stre	eet, factory, office			28f. Location (City or To			Rural Route Number,
_	To tha Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of exaurse Practitioner: To the	amination and	or invest	tigation, in my opinio	on, death of	ccurred at	the time, date	and place	e, and due to the	he cause(s) and manner stated
	To the within To the Compl	Σ	29b. Signature and title of certifier	rse Fractioner. 10 the	Desi of High	owieage,	29c. Licens	e number		ce, and due to			onth, Day, Year)
			in the warm	<u> </u>				1359	'		Jo	My 101	2012
	IOTO		30. Name and address of person wh	completed cause of de	ath (Item 23a	(Type, F	Print)	ST,	SAL	ISBUR			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	16	IVISION S						
	Registr	ar	7 7 L - 1	, Caron	J ph	1	W.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Wendell E. Eaton July 8 11:05 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick College View Center curity Number | 6. Sex Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth '. Age (In vrs. last birthday) **Funeral** Days Months Hours 579-22-2248 1 M 2 D F Director 88 Nov. 17, 1923 | Pennsylvania Usual Residence of Dece shov 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at the Maryland Director 1 X Yes 2 No Frederick Frederick Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21701 death with United States 2363 Bear Den Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. or 1 Yes 2 No WWII If Yes, Give Year or Dates. δ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 TNo Specify: er than "natural", the Medical Exa Completed White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Musical Instruments Piano Technician +2 Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jane Easton ပ Granville Eaton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2363 Bear Den Road, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Audrey M. Eaton / Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Brentwood, Maryland Fort Lincoln Cemetery 7/14/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Fart 1. Enter the disease or complications that calls shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ ovendry disease or condition Medical resulting in death) Examiner mondery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🔲 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work?
1 Yes 2 No thin 24 hours after death.

the Funeral Director: Aft
ompletely filled in by the fur Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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only one)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

homas

gistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MD 21702

29c. License number

TULINCON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23929 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month y Elliott Mary 2012 4:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home
Social Security Number 6. Sex <u>Salisbury</u> Wicomico If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 213-14-1978 Director 1 M 2 TX F 97 Yrs 06/10/1915 Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Wicomico Salisbury Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27490 Walnut Tree Road 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin 2008. 1 Never Married 2 Married Completed by ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education Bus Contractor cafeteria worker æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bertha A. Phillips Grover C. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack H. Elliott/Son 3870 Five Friars Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Johns U.M. Church 7/9/2012 Fruitland, MD Come Program Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

Approximate art 1. Enter the disease, or complications that hock, or heart failure. List only one cause on e aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death se on e Immediate Cause (Final disease or condition enysician, Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): page 2 should be detached for use as the burial-transit Cause (Disease of Injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of doub? 24a. Was an autopsy performed To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 No Yes 2 No Hospital or Attending Physician:] 24 hours after death. Funeral Director; After this certifice Be 25. Was case referred t dedicar 26. Place of Death k only one) examiner?
1 Yes 2 No Other: 4 D Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

MARY

Registrar

Mahesha Thimmarayappa M.D.

2012

10

31. Date filed (Month, Day, Year)

JUL

910 Easternshore Drive Salisbury MD

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 6,2012 Year 0029 Christine Monde Fandio Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 614-41-9358 Months Days Min 7/29/1948 1 🗆 M 2 📑 **Director** 63 Caméroon 28a-f shov items 23a or 28a-f sho her must be notified at Montgomery 10c. City, Town or Location 10d. Inside City Limits 0a State Director Takoma Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 780 Fairview Avenue 20912 Cameroon death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc ō 1 Never Married 2 X Married ģ within 72 hours after 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Health Aid 8 Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Njoya Francois Therese Nkouatchou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adline Domkam/Daughter 1376 Lloyd Thayer Circle Stockton, CA95206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ō 1 X Burial 2 ☐ Cremation 3 X Remeval from State Department of Important: If any injury or Balengou, Cameroon Family Cemetery 8/4/2012 4 Donation 5 Other (Specify) Signature PHYLPPADESRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, if any leading to immediate Examir cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death signed by the at d be detached for a \square Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 1 🗌 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify npletely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: Hospital or Attending Natural Natural (Month, Day, Year) 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner. On the basis of examination and on involuded in the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D63839 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chirumamilla Padma M.D. 7600 Carroll Ave.Takoma Park, Md 20912 31. Date filed (Month, Day, Year) 32 Registrar's Signat State

Registrar

1 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances Lenelda Ferguson 2012 July 4 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 8 1922 Funeral 9. Birthplace (State or Foreign 215-16-4677 Days Hours Director 89 Maryland 1 □ M 2 🖾 F Aug. ir than "natural", or items 23a or 28a-f show the Medical Examiner is ust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? United States Funeral 421 Hammond St, Apt. 205 21562 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housework Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F I tem 27 is marked or ၉ George Fisher Katherine Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Walosi Way, Loudon, TN 37774 Gerald Ferguson/son 146 Walosi Way, Loudon, TN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other philos Cemetery 07/07/2012 Westernport Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Wagne 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Congestive 34ems Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ tive Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ the Hospital or Attending Physician: The law requires hin 24 hours after death. the Funeral Director: After this certificate has been sign mpletely filled in by the funeral director, page 2 should be Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the F only one) 29b. Signature and title of certifier mocksh D0055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Cumperland 925 WONSOCK SHIN shop Walsh Mb 21502 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:58A M Physician/ +2 geral Medical 4a. Facility Name (if not institution, give sineet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday) Hours Months Min (Month, Day, Year) Director 228-46-2301 1 M 2 XF 75 <u>Virginia</u> Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Upper Marlboro 1 X Yes 2 No Maryland | Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20772 United States 4112 Bishopmill Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Completed by 1 Never Married 2 Married African 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates American 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Computer Operator 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပု Georgie Ross Willie Tunstall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 4112 Bishopmill Drive Upper Marlboro, Md. Carolyn Francis - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 14 2012 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Suitland, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licence 22. Name and Address of Facility Stewart Funeral Home, 20019 Washington, DC 4001 Benning Road NE M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/)au disease or condition Medical resulting in death) **Examiner** Esquer tially liet conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Vaillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) (Specify) 2 X No ဂ 1 Di Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending work within 24 hours after deau...
To the Funeral Director: Af 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier Signature 29d. Date signed (Month, Day, Year) lacic 5 0 32. Registra Registrar

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Registrar DHMH 17 Rev 06-2011

State

Blanche Mavromatis, M.D. 12502 Willowbrook Road, Suite 300 Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Blanche
31. Date filed (Month, Day, Year)

JUL 2 6 2012

Physician/ 1. Decedent's Name (First, Middle,Last) NELLIE TOMLINSON FOREMAN 4a. Facility Name (if not institution, give street and number) 126 North Main Street 5. Social Security Number 222-26-0769 1 M 2 F 80 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits	ie Foreman		State of Sta	Print in Black Ind f Maryland / Depa Cen		Health and		Hygiene	20	12 2393	
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 14, 2012 30. Name and address of person who completed cause of death (Item 23a)	DIVISI pital or Att ours after de eral Direct filled in by	Accident investigation of the determined of the							te)		
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			Punch Suitherly	(mi)				1		Month, Day, Year)	
						V. Baltimore	Street, Balti	more, MD 212	223		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05^{Day} 2012^{ear} $J_{\mathbf{u}}^{\mathsf{Menth}}$ 08:15 AM Medical 4a. Facility Name (if not institution, give street and number) 3404 Davidsonville Road 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Davidsonville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia Age (In yrs. last birthday) **Funeral** Months Days Hours 235-58-7102 Director 1 XM 2 □ F 72 25 2 should be filed within 72 hours after death with the Maryland ith and Mental Hygiene.
27 Is marked other then "natural", or items 23e or 28e-f show traumatic avent, the Medical Everniner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Davidsonville Maryland Anne Arundel 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral United States 21035 3404 Davidsonville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

XYes 2

No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pastor Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rose Balgavy Stanley Charles Golch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1 and 2 s of Health 3404 Davidsonville Road, Davidsonville, MD 21035 Ruby Golch/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Paga 1 parmit. Paga 1
Department of
Important: If it
any injury or o 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens : 07/09/2012 Davidsonville, Maryland 21. Signal re of Funeral Serv 22. Name and Address of Facility George P. Kalas Funeral Rome 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or cond on resulting in death) Physician/ Medical Due to ([/]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and ched for use as the burlal-transit The law requires that tha death certificate ba axecuted Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month detached g Unknown Division of Vital Records, P.O. ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signad paga 2 should ba de è 1 Tyes 2 No 3 Probably 4 Inknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed aftar death.

Director: After this certificate if in by the funaral director, pag 1 Yes 2 No 1 Yes 2 No or Attanding Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 5 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural Accident 5 Pending 1 Yes 2 No Investigation To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, XW4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula 31. Date filed (Month, Day, Year)

JUL 0 9 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year JULY 6 2012 Physician/ 1:00 A DENNIS LEON GREGG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Édgewater Anne Arundel South River Health & Rehab. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 246-50-1060 Director 1 🛣 M 2 🗆 F 75 Aug. 7,1936 North Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanisher must be notified at any Injury or other traumatic event, the Medical Evanisher must be notified at any lique. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Director Edgewater 1 Yes 2 No Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 21037 Funeral 144 Washington Road IISA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Athlene Harris ပ္ Robert Gregg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 Yoakum Pkwy #2413 Alexandria, Elaine Gregg / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July7,2012 Edgewater, MD Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Face al Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SOW Pnysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Use Birth 2 Fetal death IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral of the funeral director; page 2 should be detached it 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 6 8×/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 05

Registrar

31. Date filed (Month, Day, Year)

09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended iten - State Registrar #11, perF. Home, 7/17/12 BA Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:40 P M Physician/ Larry Edgar Gears Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner omico If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign cial Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 65 Director 9808 42 1 🔀 M 2 🗆 F 5/16/1947 MDUsual Residence of Decedent flied within 72 hours after death with the Maryland dal Hygiene.
d they than "natural", or items 23a or 28a-1 show yent, the Medical Examiner must be notified at yent, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Yes XXNo Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21811 9505 Shiloh Farms Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 12 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Educational system teacher permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tann any njury or other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret Morris James T. Gears, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9505 Shiloh Farms Rd. Berlin, MD 21811 Penny H.Gears (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/13/2012 Chestertown, MD Old St. Pauls Cem: 21. Signature of Fune 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Pirt 1. Enter the insease, ir complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Onset and Death Immediate Cause (Final LUNG MALIGNANT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3/☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 this certificate 1 Yes 24 1 No e Hospital or Attending Physician: 1 124 hours after death. e Funeral Director: After this certifics letely filled in by the funeral director p 25. Was case referred to medical 26. Place of Death (Check only one) 船 examiner? Other: 4 Nursing Home 5 Residence Other (Specify) HOSP142 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 5 0 120 WAS

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUL

32. Registrar's Signature

		1	For State Registrar	State of M	aryland / Dep $C\epsilon$	ertificate of l			Reg. No.	
	Physicia		Decedent's Name (First, Middle, La		G TT			2. Date of De Month 7	Day	Year 2012 5:36 P M
	/Medic	al	Jasper R 4a. Facility Name (If not institution, gir		Gue III	4b. City, Town, or	Location of Death		4c. County	
	Examin	er	21 East Orndorff			Brun	swick		Frede	
	Funeral Director		5. Social Security Number 6.	Sex 7. As	ge (In yrs. last birthday 57 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 4/20/1	th y, Year) 955	9. Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Limits
	Maryl I sho	tor	MD Freder	ick	Brunsw	rick				1XYes 2□No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	th wit	alD	21 East Orndorff			21716			USA	e - American Indian,
000	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural" or items 23e or 28e-f show or other freumatic event, it is Macical Exarch ar maint be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 1 If Yes, Give Year or Dates:	No	8. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	k, White, etc.
3	2 hou	ted	15. Decedent's 8	ducation	160 Doo	edent's Usual Occup	ation during most of work	ang	16b. Kind of Bu	siness/Industry
21212-0030	within 7 ene. then "n	Completed	Elementary/Secondary (0-12)	College (1-4or	- life.	. DO NOT use retired Laborer	i)		Carper	nter
	42 should be filed within " h and Mental Hygiene. 7 le markad other then "! freumatic event, Ite Mag		10 17. Father's Name (First, Middle, Las	t)		Lawrer	18. Mother's Nam	e (First, Middle	, Maiden Sumam	
Maryland	d be dental l	To Be	Jasper Roeback				Raetha	Fogle		
ary	shoul	-	19a. Informant's Name/Relationship			iling Address (Street				
Mi	and 2 alth a 27 le		Roy Gue, Brother			Concord D				
Baltımore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le eny injury or othar tre		20a. Method of Disposition ¹X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	9	position (Name of rematory or other place of the control of the co	^(ce) 7/13/	Date 2012	Frederic	City or Town, State
מוו	Departr Importe eny inj		21. Signature of Funeral Service Lic	per		John T Will:	ians Funera			
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_ a	ed the death. Do not ed line. A S C as a consequence of):	enter the mode of dyli	ng, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
900	Examiner and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	is a consequence of):					
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Box	The law requires that the death certificate be axecutad the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			ite of delivery onth Day Year
ds, P.O	uires that t signed by Id be detar	b	Part II. Other significant conditions	contributing to death	but not resulting in the	e underlying cause gr	ven in Part I.	1		tribute to the cause of death? 3 Probably 4 Alleknown
Division of Vital Records,	fhe law requir te has been si age 2 should l	Completed						24a. Wa auto per 1 Yes	opsy formed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
<u>ta</u>	an: Trifica	O	25. Was case referred to medical				26. Place of Dea	ath Check onl	one	
<u>Š</u>	hysici his ce I direc	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpa		tient 3 DOA			sidence 6 Oth	
o Li	ing Pl		27. Manner of Death 1 PNatural 5 Pending	28a. Date of Ir (Month, L	njury 28b. Time Day Year) Injur	ry Wo	iry at ork?] Yes 2 ☐ No	28d. Describe	how injury occur	190
Divisio	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	Certification;	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place of	Injury - At home, farm, etc. <i>(Specify)</i>			28f. Location City or T	(Street and Numb own, State)	ber or Rural Route Number,
-	Hospite 24 hours Funerel stely filled	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Expone)	Physician: To the be aminer: On the basis and manner	st of my knowledge, do s of examination and/o stated.	eath occurred at the trinvestigation, in my	ime, date and place opinion, death occu	e, and due to th urred at the time	e cause(s) and m e, date and place,	anner as stated. and due to the cause(s)
	omple	Me	29b. Signature and title of certifier				se number			ed (Month, Day, Year)
	⊢ ≶ ⊢ ō		1 Hours	ho		D-	3191	2	7/1	5105/1
197	3		30. Name and address of person w		of death (Item 23a) (Ty	pe, Print)		CAEN	ENNI.	402170
	~		JULIO MENOCA		10 13 140(OHMAN	stone.	Life !	1210109	· · · · · · · · · · · · · · · · · · ·
	St Regist	ate	31. Date filed (Month Pay, Year)	2012 32.409	strar's Signature	parket				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07-Physician/ Medical la facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner COMI If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) 215-82-6731 Director 1 X M 2 □ F Maryland 11-27-1961 50 Usual Residence of Decede item 27 is marked other then "nature!", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County the Maryland Director 1 X Yes 2 No Salisbury MD Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours efter death with USA 21804 606 S. Park Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 【X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then eny injury or other treumetic event Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked 12 Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beverly Clow Gordy, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 S. Park Drive, Salisbury, Maryland 21804 Howard L. Gordy, Jr. - Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-5-2012 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 □ No a 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence (**POther (Specify)) HOSPICE Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: **1** Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8400 05 R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21801

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ A M 2012 7:59 Sandra Yvonne Greene July 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton 4900 Plata Street 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Numbe Age (In yrs. last birthday, **Funeral** Hours **Director** 1 □ M 2 🖺 F 579-62-4756 64 Nov 5, 1947 Washington, DC Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Prince George's Clinton Md 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral USA 20735 4900 Plata Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or itel Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** 3 Widowed 4 X Divorced Completed Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 in Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic events." (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Private Human Resource Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lenora Thomas Thomas Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarksburg, NJ <u>Vann DuWayne</u>Battle / Brother 2 Hannah Mount Dr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Cemetery 7/13/2012 Brentwood, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Fort Lincoln
3401 Bladensburg Rd Brentwo

23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail are. List only one cause on each line. 22. Name and Address of Facility Fort Lincoln Funeral Home 20722 3401 Bladensburg Rd Brentwood, Md Approximate Interval Between Onset and Death Immediate Cause (Po 3 months Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Examiner Unknown Tobacco Abuse Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Unknown Asthma that initiated events Due to (or as a consequence of) resulting in death) Last burialnding physician by Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter for in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 X No 9 Unknown q Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Type II Diabetes Mellitus 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has l autopsy performe Yes 2X No 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Within 24 hours after death.

To the Funeral Director. After the Funeral Director. injury 1 X Natural 5 Pending Accident
Suicide Certificat 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital

State Registrar 29b. Signature and title

Lara Adejumo, MD 31. Date filed (Month, Day, Year 32. Registrar's Signature

30. Name and address of person who competed cause of death (Item 23a) (Type, Print)

00684

10403 Hospital Dr. Suite 103 Clinton, Md

29d. Date signed (Month, Day, Year)

20735

amend 15 Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 7, Day 2012 Physician/ 4:30 Thelma F. Garnett Medical 4a. Facility Name (if not institution, give street and number)
Rehabilitation 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Fort Washington Health & Fort Washington 8. Date of Birth (Month, Day, 5. Social Security 84755 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Director 83 577-44-8435 une Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State lid be filed within 72 hours after death with the Maryland Mental Hygiene. "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1- Yes 2 □ No Maryland Prince George's Capitol Heights 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral 20743 United States 1207 Addison Road # 103 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: 3 x Widowed 4 ☐ Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Housewife 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Novella Conway Henry Rich permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20735 2509 Lazy Acres Road Clinton, Maryland Cheryl Garnett - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Suitland, Maryland Lincoln Cemetery 4 Donation 5 Other (Specify) Stewart Funeral Home, 22. Name and Address of Facility Signature of Funeral Service Licensee Slewer 20019 Washington, DC Some L. 4001 Benning Road NE M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death atheroscleros. Immediate Cause (Final disease or condition · Rrebrovascular Pnysician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ₩ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature of title of certifier 2012 042955

Registrar

Name and address

31. Date filed (Month, Day, Year

2 2012

death (Item 23a) (Type, Print)

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32. Registrar's Signature

on who completed cause

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12017 Ft Wesh Re

State of Maryland / Department of Health and Mental Hygiene
AMEND #20b, 20c per fh 7/13/12

Reg. No.

Reg. No. 1 - For State Pagistrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1340 P_{M} ESSIE BELLE GREEN JULY Medical Examiner Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SPRING MONTGOMERY SILVER Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, If Under 24 Hrs **Funeral** Min Year 577-48-6546 **Director** 1 🗆 M 2 🔀 F 08-19-1929 GA 82 Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director WASHINGTON 1X Yes 2 ☐ No DC ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20019 US death with 1167 46TH PLACE, SE items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1. Marital Status 14. Race - American Indian, Black, White, etc. o ò 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", Specify: BLACK 3 XWidowed 4 Divorced Completed Year or Dates Jule. or than "he. "he Medical F 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha PRIVATE CHEF traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GERTRUDE DYER MATTHEW MATHIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. DEBORAH GREEN-WILSON/DAUGHTER 4709 FAULKLAND RD, COLUMBIA, SC 29210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 7-13-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility POPE FUNERAL, HOMES, P.A. m01623 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physicians/ ASPIRATION PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ADVANCED DEMENTIA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of death certificate be executed -tran and that initiated events Due to (or as a consequence of) resulting in death) Last -burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE ISe 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ō Day Year Pregnant at time of death g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires SACRAL DECUBITUS ULCER 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 🗌 No 2 X No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2X No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury after death. Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN RD, SILVER SPRING, MD 20910 SARAH BROMELAND, M.D. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan	-	artment of H tificate of D		Mental Hy	giene Reg. No.	012	23943
	Dhysisis	.,	Decedent's Name (First, Mi	ddle, Last)					2. Date of De	ath	Vear	3. Time of Death
~.	Physicia Medic	_	ELLSWORTH		GARRETT				JULY	05, 2	012	07:45 A ^M
	Examin	er	4a. Facility Name (if not institu HOLY CROSS	HOSPITAL			4b. City, Town, or SILVER	SPRING	n		ty of Death GOMER	Y
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. 8. Date of Bir (Month, Da	th	g. Birth Cour	place (State or Foreign
	Director		218-82-4133 Usual Residence of Decede	1 X M 2 □	_F 51	Yrs.	,			/1960		MD
	land show d at	tor	10a. State 10b. Cou		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	MD 10e. Street and Number	PG	LAUR	EL	10f. Zip Code			40- 00-	5 10 th = 4 C =	1 X Yes 2 No
	vith th	eral	12705 SILVERB	IRCH LANE			20708			10g. Citizen o	i what Cou	nury r
	death vitems	Funeral	11. Marital Status	12. Was D	ecedent Ever in U.S Forces?	S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S	pecify Yes or No- to Rican, etc.)		ace - Americ	
36	after o	d by	1 ☐ Never Married 2 ☐X 3 ☐ Widowed 4 ☐ Divo	. If Yes,	Forces? es 2 No Give Dates.		☐ Yes 2 🗓 No		, ,		fy: BLAC	
21215-0036	hours natura dical E	Completed	15. Dec	edent's Education ighest grade complet			dent's Usual Occupa kind of work done d		rking	16b. Kind of		
121	hin 72 ne. than " te Me)omo	Elementary/Secondary (0- 12TH		e (1-4 or 5+)	life. D	O NOT use retired) DER	anng most or wo	iking	 PRIVAT	יני	
2	led wit Hygie other ent, th	Be (12.1n 17. Father's Name (First, Midd	lle, Last)		WEL	DEK	18. Mother's Na	me (First, Middle,			
ylan	should be file and Mental h 7 is marked o raumatic eve	입	NORMAN GARRET	T				MABEL J	OHNSON			
Maryland	shoul h and l 7 is m trauma	1	19a. Informant's Name/Relati			T	ng Address (Street a					Code)
	I and 2 I Health Item 2 other I		PEGGY S. GARR 20a. Method of Disposition			lace of Dispo	SILVERBI sition (Name of		E, LAUREL Date	MD 20 20c. Location		own, State
m 0	Page nent or ant: If Iry or		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		om State		vetery or other place	7-1	6-12	CHELTE	ENHAM,	, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of timeral Serv			22	Name and Addres					
	40 = e o	_^^	23a. Part 1. Exter the diseas	molu25	at caused the deat		538 MARLE		-		MD ZC	Approximate
يند	Physician/		shock, or heart failure. I Immediate Cause (Final disease or condition	ist only one cause or								Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due	to (or as a consequ	uence of):	ONARY ARI					
	LAGITIMICI	er	Sequentially list conditions,	b. —	ADREN		ICER-METAS	STATIC			-	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(
	ate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due	to (or as a consequ	uence of):						
760	death certificate be executed he attending physician and ted for use as the burial-transi	edical		d								
Division of Vital Records, P.O. Box 687	eath certifica s attending p d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnanc	v			Date of deliv	
Bô	e death the att hed fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ P	regnant at time of o		Other (specify)			_ N	1onth	Day Year
P.O.	requires that the des been signed by the s should be detached	by Ph	Part II. Other significant cor	ditions contributing t	o death but not res	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
ds, l	quires t	ed b							1 🗆	Yes 2 ☐ No	3 \square Pro	obably 4 🔀 Unknown
COL	law rec nas be e 2 sh	Completed					-		24a. Was	psy	prior to co death?	opsy findings available ompletion of cause of
- Re	n: The ficate or, pag		25. Was case referred to med	ical			26 Pla	ace of Death (Che		ormed? 2 X No	1 Yes	2 🗓 No
Vita	ysicia is certi direct	To Be	examiner? 1 Yes 2 X No	Hospital:	X Inpatient 2	ER/Outpatie	Othe	er.	Home 5 Res	idence 6 🗆 O	ther (Specif	(y)
10	ing Ph	ate:	27. Manner of Death 1 X Natural 5 ☐ Pe	/8	ate of injury Nonth, Day, Year)	28b. Time of injury	work	?	28d. Describe	how injury occu	rred	
Sior	l or Attendi after death Director: A I in by the f	Certificate:	2 \subseteq Accident Inv	vestigation ould not be 28e. Pl	ace of Injury - At ho	ome, farm, str		Yes 2 No	28f. Location	Street and Num	ber or Rura	al Route Number,
DIX:	tal or A		4 ∐ Homicide de	termined bu	uilding, etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medi		basis of examination	n and/or inves	tigation, in my opinic	n, death occurred	at the time, date	and place, and o	due to the ca	ause(s) and manner stated.
	To the within to the somple	Σ	only one) 3 L Certing 29b. Signature and title of certing 29b.	fying Nurse Practitio	ner: Io the best of r	ny knowledge	29c. License	number	piace, and due to	the cause(s) and 29d. Date sign		
	Q _e		Sunfl	The	in	TMS	D6506	9		7-6	- 20	12
	PD'		30. Name and address of per					STLVER	SPRING			
	Sta	te	31. Date filed (Month, Day Ye				JUEN KD.,	STUVER	DI KING,	209		
	Registr		JUL 1 1 201	c ferre	2. Registrar's Sign	GL/EL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 9, July Physician/ 7:17 A 2012 Violet Pauline Golden Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hancock 223 Myers Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Country) 219-14-8831 Director 1 M 2 KF MD 88 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov notified at 10c. City, Town or Location 10a. State with the Maryland Director 1X Yes 2 No Hancock MD Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number iral", or items 23a or Examiner must be Funeral USA 21750 223 Myers Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If flem 27 is marked other the any injury or other traumant. Armed Forces Black White, etc. þ 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Myrtle T. Brady Frank Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17267 2718 Great Cove Road Warfordsburg, PA Dennis K. Golden/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 07/21/2012 Hancock, MD 4 Donation 5 Other (Specify) St. Thomas 'Episcopal 22. Name and Address of Facility 141 West Main Street ature of Funeral Service Licensee Grove Funeral Home, P.A. Hancock, MD 21750-0368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final disease or condition Physician/ erebrovascu Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed to should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? cate has page 2: 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director, After Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check weducat zaminer. On the beast of beatting and a state of the state of the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2012 135020 Mures 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allison Kriner-Wade CRNP Two Tonoloway Hancock, MD 21750

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JIII

26

State of Maryland / Department of Health and Mental Hygiene 23945 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Howes Ann Teresa July 10 12:14A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Hours 5/14/1955 57 Maryland **Director** 220-66-5815 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

The state of Health and Mental Hygiene. The state of Health and Saa on state if item 2.75 is marked other than "natural", or items 2.3a on sury or other traumatic event, the Medical Examiner must be sury or other traumatic event, the Medical Examiner must be. Funeral 130 Hearne Road #1013 USA 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ticket Agent Bow Tie Cinemas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Goddard John W. Howes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie M. Krause/Sister 427 Edgemere Dr., Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of Sorrows Cem.7/13/2012|West River,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 2973 Solomons Island Rd., Edgewater, MD 21037 Page 1. Enter the disease, or complicat shock, or heart fallure. List only one ca ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Due td dras a consequent Immediate Cause (Final Onset and Death Physician/ respiratury disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No. Records, 1 Yes 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28d. Describe how injury occurred 1 Anatural 5 Pending s after death.
I Director: Afted in by the fur 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in t 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Mertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 7-10-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapulis,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

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JUL 11 2012

Anne Anundel Medical Center, 200) Medical Parkhay

MD 2140

State

. Date filed (Month, Dav. Year,

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State of Maryland / Department of Health and Mental Hygiene 2012 2

	•	For State Registrar	to or maryiane	Cer	tificate of E	Death	Re	eg. No.			
Physicia	ın/	Decedent's Name (First, Middle, Last)	········				2. Date of Death		201 ^V 2 ^{ar}	3. Time of 2035	Death P M
Medic Examin	cal	MARIE LORRAINE HUG	d number)		4b. City, Town, or BERLIN	Location of Death	JOBI	4c. Cc	unty of Death	1	2 101
Funeral Director		ATLANTIC GENERAL F 5. Social Security Number 6. Sex 004−38−8949 1 □ M 2	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-5-192	Year)	9. Birti Cou	nplace (State or intry) INE	r Foreigi
Maryland 28a-f show stified at	Director	Usual Residence of Decedent 10a. State DELAWARE SUSSEX		Town or Loc						10d. Inside Cit	
with the s 23a or 3	Funeral Di	10e. Street and Number 34280 VINES CREEK			10f. Zip Code 19939			υ.	n of What Co		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 X Married 1 If You	s Decedent Ever in U.S. ned Forces? Yes 2 X No es, Give r or Dates.	1	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Amer Black, White ecify: WH		
21215-0036 within 72 hours after giene. er than "natural", of the Medical Exam., the Medical Exam.	Completed	15. Decedent's Education (Specify only highest grade complete (Specify only highest grade complete (O-12) Col	oleted) lege (1-4 or 5+)	(Give I life. Di	lent's Usual Occup kind of work done of D NOT use retired) DMEMAKER	ation during most of work	ing	16b. Kind	of Business/I	ndustry	
Maryland 2 2 should be filed w Ith and Mental Hyg 27 is marked othe	To Be	17. Father's Name (First, Middle, Last) CLAYTON MARTIN				18. Mother's Nam		laiden Sur	name)		
Mar. nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship (Type, Prin WILLIAM W. HUGHES/HU	SBAND	P.O.	BOX 1546	o, OCEAN	VIEW, DE	LAWAI	RE. 199	939	
Baltimore, sernit. Page 1 and Separtment of Hee mportant: If item any injury or othe once.		20a. Method of Disposition 1	o Ce	E OF 1	sition (Name of natory or other place HEAVEN CE	7-13-	-12	DAGSI		DELAWAR	E
Bal- permit Depart Impor		21. Signatule of Funeral Relivity 10				NERAL SER			W, DE.	19970 Approximat	
Physician Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		Sep	S/S	g, such as calculate	or respiratory arre			Interval Bet Onset and I	ween
Examiner	ı.	Sequentially list conditions b.	Oue to (or as a consequence of the consequence of t	vs-bvc	vascul	er acci	dent				
3760 ficate be executed g physician and as the burial-transit	cal Examiner	Cause (Disease or injury	Due to (or as a consequence to	12ur ence of):	e Disa Structi	rder ve Puli	nonanj	Di	sease		
Box 68 death certi	Physician/Medical	in the past 12 months?	es, outcome of pregnar Live Birth 2 Feta Pregnant at time of d Unknown	ncy I death 3					d. Date of de Month	livery	Year
IS, P.O.	ed by Phy	Part II. Other significant conditions contribution.	ng to death but not rest	ulting in the u	underlying cause gi	ven in Part I.				the cause of c	
Records, The law requires ate has been sig	Completed by						24a. Was a autop: perfor 1 \(\sum \) Yes		prior to death?	topsy findings completion of c	availa cause
of Vital ig Physician: ter this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1: 1 XInpatient 2 a. Date of injury (Month, Day, Year)	ER/Outpatie 28b. Time o injury	nt 3 DOA Oth	4 □ Nursing H ry at	ome 5 Residence	_		ify)	
Division Hospital or Attendir 24 hours after death. Funeral Director: After of filled in by the fu	Il Certificate:	3 Suicide 6 Could not be 4 Homicide determined 286	e. Place of Injury - At ho building, etc. (Specify	"			28f. Location (S City or Town	n, State)			ber,
the Hospital nin 24 hours the Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On only one) 3 Certifying Nurse Prac	the basis of examination	and/or inves	tigation, in my opin e, death occurred at	on, death occurred the time, date and p	at the time, date ar lace, and due to the	nd place, a ne cause(s)	and manner a	cause(s) and ma as stated.	anner :
To t with		29b. Signature and title of certifier SCA THUM	10 AM (1	Atten	29c. Licens				signed (Mont		2
BA8		30. Name and address of person who completed the state of	amnas	973	Print) Heal	DS6312 thway	Drive	B	alin,	mD	21
St: Regist	ate rar	31. Date filed (Month, Day Year)	32. Registrar's Signa	lure A			ě.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8: 45 AM HRUSKA ゴビト 01 2012 ARILYN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LEASANT VIEW NURSING HOME AIRY CARROLL TOUGH If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 7/21/1940 Director 215-40-7079 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County irector 10c. City. Town or Location 10d. Inside City Limits notified at 1 Tes 2 To No MD Carrol1 Mount Airy ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral 21771 Baltimore National 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Ves 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Horse Trainer Horse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ traumatic Paul Dennis Reid Ann Fox Olivier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Two Rivers Road, Chesapeake City, MD 21915 Ann Mechling - sister 159 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/7/2012 4 Donation 5 Other (Specify) PA Funeral Home, Rising Sun, MD 21. Signature of Funeral Serving L 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 East Main Street, Elkton, MD 21921 239 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or respiratory) Approximate Interval Between Onset and Death UBSTRUCTIVE PHIMONARS MONIC Pnysician/ disease or andition resulting i death) Medical Due to (or as a consequence of) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law r hin 24 hours after death. the Funeral Director: After this certificate has b cate has be pared as prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 No After this certifical funeral director, p Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 1 Matural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald 4 DRIVE, ULWELL AIR MOUNT MARY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mehrle Lewis Hobbs Jr July 7 2012 7:10 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 220-92-2850 **Director** 46 1 XM 2 | F Maryland June 4, 1966 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he national once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Frederick Mount Airy 1 🗌 Yes 2 🔀 No Maryland 10e, Street and Number 10g. Citizen of What Country? 21771 United States 13530 Old National Pike 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Painter Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Handley Mehrl Louis Hobbs, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13530 Old National Pike, Mt. Airy, MD 21771 Shayne Hobbs / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 9, 2012 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Resthaven Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundamental Control of Cont Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter th or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failu Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Seven Medical Due to (or as a consequence of) Examiner eumour Sequentially list conditions, it can be accounted to the cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as for use Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death?
1 Yes 2 No performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 1 ☐ Yes 2 XNo 1 🗶 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director; A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

seven

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23b per doc 9931 9-11-12 years and item 23b per doc 11-12 years are all Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 | 2 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:30 PM 2011 Wayne William Hopson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico bure at If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 1 ፟M 2 □ F Director 554-28-9789 86 09-19-1925 permit. Paga 1 and 2 should ba filad within 72 hours after daath with the Maryland Department of Health and Mantal Hygiane. Important: If item 27 is merked other than "natural", or items 23e or 28a-f show my injury or other traumatic event, the Medical Examinet must be notified at ONCE. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b Count Director 1 Yes 2 No MD Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21801 USA 423 Dogwood Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 1 Never Married 2 K Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highe rade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plant Manager Swanson-Campbell Soup Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Cynthia Virginia O'Dell Carl William Hopson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 Dogwood Dr. Salisbury, MD, 21801 Lela I. Hopson Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Vet. Cemetery 7-11-2012 Hurlock, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. , Salisbury, MD, 21804 Snow HIll Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition CHRONIC Physician/ RANAL FAILURR Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Kidney Disease IV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ata has baan signad by the attanding physician and paga 2 should ba datached for use as tha burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death cartificate be axacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? rs aftar daath. •• Director: Aftar this certificata ha lied in by the funaral director, paga 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence of Other (Specify) HOSP (42 1 🗌 Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural
Accident 5 Pending М Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3/27 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Hayan WAR UP 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2012 JUL 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ a_M 6:34 07 2012 Medical Bernice M. Hines 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital <u>Clinton</u> Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Months Hours 579-20-1256 Director 1 □ M 2 🏝 F 86 04/01/1926 South Carolina Usual Residence of Dece show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at the Maryland **Funeral Director** notified 28a-f s 1 X Yes 2 ☐ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ь must be 23a Page 1 and 2 should be filed within 72 hours after death with 2606 Naylor Road, SE #202 20020 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iter Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates er than "nature the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other than the reaumatic event, the N Private 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Rebecca Hering Edgar Reedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2606 Naylor Road, SE #202 Washington, DC 20020Richard Hines - Husband item 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ott once, 1 🖾 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Lincoln Cemetery 07/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final d Physician/ disease or condition resulting in death) Medical Due to (of a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attenuing Physician: The law requires that the death certificate be executed and the burial-trail that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ☐ Live Birth ∠ ☐ 1000 Cath
☐ Pregnant at time of death
☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☑ No ō Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performed 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 🖹 ER/Outpatient 3 🗌 DOA မှ this 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide Investigation Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato of mo	il y lai la	Cen	tificate of l	Death		Reg. No.			
н	Physicia	n/	1. Decedent's Name (First, Middle, I					-	2. Date of Dea Month	Day	Year	3. Time of Death	
	Medic	al	WILLIAM DONALD				4. 60. 7	Landing of Dooth	JUNE	30	2012	11:50 P ^M	
	Examin	·	4a. Facility Name (if not institution, g		OFFILE	urm		r Location of Death ETHESDA		4c. (County of Death MONTG	OMERY	
	Funeral		WALTER REED NATI 5. Social Security Number 6	. Sex 7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h (-Voor)	9. Birth	place (State or Foreign	
	Director		278-32-0560	1 X M 2 □ F	76	Yrs.	Wortins Days	Tiours Willi.	March, Da	1, 1	936	Ohio	
	nd how at	7	Usual Residence of Decedent 10a. State 10b. County		10c. City, To						1	0d. Inside City Limits	
	faryla 8a-f s tified	ect			Wash	ingto	ton, D. C.			1 XX Yes 2 □ No			
	the A	Ö	10e. Street and Number				10f. Zip Code	·			10g. Citizen of What Country?		
	ns 23: must	Funeral Director	300 Massachusett			1.60	2000	_			USA		
10	or iter	by Fu	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Never						Rican, etc.)	1	 Race - Americ Black, White, 		
93	s afte ral", c Exan	q pa	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1990	1	☐ Yes 2 X No	Specify:		S	specifyWhite	9	
5-0	2 hour "natu	plet	15. Decedent (Specify only highest		1111	(Give k	lent's Usual Occup	during most of worl	king	16b. Kir	d of Business In	dustry	
21215-0036	thin 7 ene. than he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5-	-)		O NOT use retired) oldier			U .	S Army		
d 2	lled w I Hygi other rent, t	Be	17. Father's Name (First, Middle, La	st)			010101	18. Mother's Nan	ne (First, Middle,				
/lar	d be f Menta arked	잍	Charles Hayo	len				Go1	die Gill	and			
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Tei F. Hayden/V					and Number or Rul					
Jre,	of Head of Head fitem		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3	Chata			sition (Name of natory or other pla	ce)	Date	20c. Loc	cation - City or To	own, State	
ij	ment ment tant: I		4 Donation 5 Other (Sp	ecify)		gton N	ational Ce	metery 7	/12/12	Ar1	ington,	VA 22203	
Balt	permit Depart Import any in		21. Signature of Funeral Service Lie	ensee	425		. Name and Addre	ess of Facility 4510 Wil:	son Blvd	l. Ar	1, VA 22	2203	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on		the death. [o not ente	er the mode of dyir	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between	
	Pnysician/	ΥÏ	Immediate Cause (Final disease or condition	PANCREA	ATIC C	ANCE	3					Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequen	ce of):							
	uted Id	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	C									
	e exec		resulting in death) Last	Due to (or as a	consequen	ce of):							
8760	physic the b	edic		d									
.89	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			15			2	3d. Date of deliv	ery	
Box 6	Attending Physician: The law requires that the death certificate be executed er death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnan Other (specify)				Month	Day Year	
P.O.	at the		Part II. Other significant condition	s contributing to death bu	ıt not resulti	ng in the u	nderlying cause g	iven in Part I.	23e. Did to	obacco us	se contribute to t	ne cause of death?	
S, F	uires the signer of signer of the signer of	sd by							1 🗆	Yes 2	No 3□ Pro	bably 4 🗆 Unknown	
oro	w require s been si 2 should	Completed					_		24a. Was			psy findings available impletion of cause of	
Rec	The law cate has page 2:	Som							perfo	rmed? 2 X No	death? 1 🗌 Yes	·	
tal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. F	lace of Death (Che	ck only one)				
Ϋ́	Physion this of the real direction	2	1 Yes 2 XNo 27. Manner of Death	1 X Inpatie		NOutpatien Bb. Time of	nt 3 🗆 DOA	4 ☐ Nursing F	lome 5 Resident		Other (Specify occurred	/)	
o uc	nding ath. :: After	icate	1 X Natural 5 Pending 2 Accident Investiga	(Month, Day,	Year)	injury	wor	ḱ?] Yes 2 □ No		,,			
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 Suicide 6 Could not determine			e, farm, stre	eet, factory, office		28f. Location (S City or Tov		Number or Rura	Route Number,	
۵	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		29a. Certifier 1 😾 Certifying I	Physician: To the best of r	nv knowled	ge death o	occured at the time	e, date and place a	and due to the ca	use(s) and	i manner as state	ed.	
	n 24 h	Medical	(Check 2 Medical Ex	aminer: On the basis of ex Nurse Practioner: To the b	amination a	nd/or invest	tigation, in my opin	ion, death occurred	at the time, date a	and place,	and due to the ca	use(s) and manner stated.	
	To the vithing to the complex		29b. Signature and title of certifier				29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)	
	jo		- Settes to			-1 /		9492-20		<u> </u>	ly Q	012012	
	14		30. Name and address of person w	no completed cause of de 3H , MD	eatn (Item 23	sa) (Type, P		REED NAT DA, MD 20		EDIC.	AL CENTI	LK.	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	N.	DETHEO	DE 110 20					
	Registr	ar	JUL 1 1 2012	BELLEVILLE DO.	100	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Harrison 1:15 P. M Physician/ G. Juanita Iu1y 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing & Rehabilitation Prince George's Adelphi If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 508-14-1456 **Director** 1 M 2 F 93 July 28, 1918 Kansas Usual Residence of Decedent show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location must be notified at Director Adelphi 28a-f Maryland Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ö 20783 ral", or items 23a Examiner must be Funeral U.S.A. 3210 Powdermill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Black, White, etc. Armed Forces?

1 Yes 2X No permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonee. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Currency Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maider, Surgame) Thomas Gary မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $800\,$ Cannon Road Silver Spring, Maryland $^{20}904$ 19a. Informant's Name/Relationship (Type, Print) Richard R. Harrison, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Quantico Nat. Cemetery 7/13/2012 Triangle, Virginia 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. N.W. Washington, D.C. 20011 21. Signal re of Funeral Service License at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrhythmia Physician/ minutes disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10 yrs. Congestive Cardiac Failure Sequentially list conditions, Examine d any, leading to immediate cause. Enter Underlying Cause (Disease or injury Days to for as a consequence of 15 yrs. Coronary Artery Disease To the Hospital or Attending Physician; The law requires that the death certificate be executed ttending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last 5 yrs. Physician/Medical Renal Failure Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Peripheral Artery Disease, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertensive Cardiovascular Disease-LVH 24a. Was an has e 2 autopsy s certificate has lirector, page 2 Osteoarthritis Multiarticular performed? 1 ☐ Yes 2 X No 2 L N __ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the: Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License number D17843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3811 Toledo Terrace SuiteBl02 Hyattsville, Maryland 20782 Vaid, MD Vivek C.

29d. Date signed (Month, Day, Year) July 10, 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 9 ogPM James Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 579-48-4087 1**X** M 2 □ F Director 76 11/25/1935 NC Usual Residence of Decedent show 10d. Inside City Limits 10b County 10c. City. Town or Location at 10a. State the Maryland Director must be notified 1 X Yes 2 No 28a-f MD PG SEAT PLEASANT 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral US 606 64TH PLACE 20743 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Medical Examiner Armed Forces Black, White, etc. or 1 Never Married 2 Married þ 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify BLACK If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the FARMER PRIVATE other traumatic event, Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIE HARRISON ETTA HEDGEPETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a BARBARA B. HARRISON/WIFE 606 64TH PLACE, SEAT PLEASANT, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other plants
MARYLAND VETERANS
CEMETERY Department o Important: If any Injury or once, Injury or 7-16-2012 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. ignature of Frn al Service Licensee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 mo1623 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Prieumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events ESRD and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Yea 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Sarco.dusis Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DUT'S 24a. Was an autopsy performed? Yes 2 No has page 2 after death.

Director: After this certificate SPLUMIC Notice. 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Maligner 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [29b. Signature and tible of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D00 1104182658 July 7, 2012 JASAR 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Bultimore MD 21201 Adam Jaine MD 5 Greene ST 31. Date filed (Month, Day, Year) State 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** arvin adison /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saltimore anes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Vear 154M 2□ F Months Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Nes 2 No **Funeral Director** MD 10g. Citizen of What Country? 10e. Street and Number 23a or 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 Do If Yes, Give 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖾 0o Specify. þ Black 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau hristina Richardson City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) BA HIMOS 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee SCATO art1. Enter the disease, or complections that caused the death. Do not onter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ver /Medical Due to (or as a consequence) f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yes Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 Ho 3 Probably 4 Unknown nKnown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed' this certificate 2 No 1 No 2 Ves 2 □ No 1 Nes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 🗓 lo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 29b. Signature and title

DOYCE

31. Date filed (Month, Day, Year)

and manner stated.

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 3 Physician/ Brianna Jiminez Day 2012 Year 11:41 AM Medical 4b. City, Town, or Location of Death Baltimore City 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** The Johns Hopkins Hospital Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country Newark, DE 1 □ M 2 😾 F Dec 3 1997 221-90-1653 14 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE 1 Yes 2 No Kent Clayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 19938 United States 217 Huntington Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force

↑

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Yes 72 hours after Baltimore, Maryland 21215-0036 1X Yes 2□No Specify: Trinidadian If Yes, Give B1ack Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student should be filed with and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည April Toussaint Stanley Jiminez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Jiminez 217 Huntington Drive, Clayton, DE 19938 1 and 2 s of Health item 27 (father) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place 1 Burial 2 Cremation 3 A Removal from State Donation 5 Other (Specify) Wilmington, DE All Saints Cemetery 7-7-12 Newark, DE 19702 Signatu e of Funeral Service License 22. Name and Address of Facility Þ CC0283 Beeson Funeral Home, 2053 Pulaski Highway Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line mmediate Cause (Final Herniation Syndrome Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Astrocytoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury and-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.

Funeral Director. After this certificate has been signed by the attending physicis leted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes ဂ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fraction or To the best of my knowledge seath accounted the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 3, 2012 T7215 MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

0

backer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christina L. Cifra, MD, 1800 Orleans Street, Baltimore, MD 21287

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	• · · · · · · · · · · · · · · · · · · ·	(Certificate	of Deat	th	,	Reg. No.		
	Physicia	n/	Decedent's Name (First, Middle, Last)						2. Date of Dea	Day	Year	3. Time of Death
	Medic	al	Dorothy Grace Jo						67	020	2012	1828 M
	Examin	er	4a. Facility Name (if not institution, give st	L Medical	Per ker	4b. City, T	own, or Locat	36414		4c. County	of Death	in
المين -	Funeral		5. Social Security Number 6. Sex		yrs. last birtho	lay) If Under	1 Year If Ur	nder 24 Hrs.	8. Date of Birt	th	9. Birthp	ace (State or Foreign
	Director]м 2 😾 F	86 Y		Days Hou	urs Min.	(Month, Da 09/10/	y, Yea <i>r)</i> 1925	Flor	ida
	nd how	'n	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	or Location					10	d. Inside City Limits
	larylar 3a-f s	Director	MD Wicomico			isbury						1 ☐ Yes 2 🔀 No
	or 26	ı Dir	10e. Street and Number			10f. Zip	Code			10g. Citizen of	What Count	ry?
	s 23e	Funeral	803 Kearney Cou	ırt			21804			USA		
	death r item		· · · · · · · · · · · · · · · · · · ·	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Decede If Yes, specif	ent of Hispanio fy Cuban, Me	o Origin? (Spe xican, Puerto	cify Yes or No- Rican, etc.)		e - America ck, White, e	
36	s after el", o Exam	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 😾 Divorced	1 ☐ Yes 2 😾 No If Yes, Give Year or Dates.		1 ☐ Yes 2	No Spe	ecify:		Specify		ite
ŏ	within 72 hours after death with the Maryland glene then "naturel", or items 23e or 28e-f sho the Medical Evaminer must be rollilled at	Completed	15. Decedent's Edu	cation	16a. D	ecedent's Usual	Occupation			16b. Kind of B	usiness/Ind	ustry
2	nin 72 ne. then "	E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		Give kind of work fe. DO NOT use	retired)		ng			
2	d with	BeC	17. Father's Name (First, Middle, Last)	5+	J	School			/Five A. B. distable		<u>ation</u>	
aŭ	be filed ental Hyg ked oth ic event	٥	Ernest Crowson						izabeth	Maiden Sumam Kuhn	e)	
ary	1 end 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygene. of Heelth and Mental Hygene. for them 27 is marked other then "naturel", or items 23e or 28e-f show there freumetic event, the Medical Evaniher must be relified.		19a. Informant's Name/Relationship (Type	e, <i>Print</i>)	19b. I	Mailing Address	Street and Nu	ımber or Rura	I Route Numbe	r, City or Town, S	State, Zip C	ode)
Σ	nd 2 s eelth om 27 i		John G Johnson, II	I /son	330	060 Gord	ly Rd.	Laure1	, DE 19	956		
Baltimore, Maryland 21215-0036	ge 1 e nt of H :: If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	Removal from State	cemetery,	isposition (Name crematory or oth	her place)		Date	20c. Location	-	vn, State
┋	permit. Page Depertment o Important: If eny injury or once,		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		remato	ry of De			4/2012	Delmar	, DE	
Ba	Depe Impo eny i		21. Signature of Funeral Service Licenses	·		22. Name and Short F			13 E Gr	ove St,	Delma	r,DE 19940
			23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one	cations that caused the	death. Do not	enter the mode	of dying, suc	h as cardiac o	r respiratory an	rest,		Approximate Interval Between
-	nysician/		Immediate Cause (Final disease or condition	1.11	sclaron	lie Co	ronary	arte	nal cl	sease		Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of)		0					
		Je.	Sequentially list conditions, if any, leading to introducte	Due to (or es a no	nsequence of)							
	d d ensit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
	e exectien ar	al Ex	resulting in death) Last	Due to (or as a co	nsequence of)							Ì
8760	ificate be executed g physicien and as the buriel-trensit	Medical	d	1-	·							
			IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p						23d Da	ite of delive	n,
Box	death e etter	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		3 ☐ Ectopic pr 5 ☐ Other (spe						Day Year
P.O.	The law requires thet the death certi ate has been signed by the ettendin page 2 should be detached for use	Physician/	9 Unknown		-4			D	T			
٠ <u>٠</u> .	es the signec I be d	þ	Part II. Other significant conditions con	inbuting to death but h	ot resulting in	the underlying ca	ause given in	ran I.				e cause of death?
ğ	requir been s	etec				-			24a. Was			sy findings available
Records,	siclen: The law i certificate has b lirector, page 2 s	Completed							autop perfo	osy ormed?	prior to con death?	pletion of cause of
		Be C	25. Was c referred to medical		8		26. Place of	Death (Check		2 P No	1 🗌 Yes	2 □ No
<u> </u>	Physici this cer ral direc	10 E	examiner? 1 Yes 2 No	ospital: 1 lnpatient	2 ER/Outp	atient 3 DO	Other: 4	☐ Nursing Ho	me 5 🗆 Resid	dence 6 Oth	er (Specify)	
יסל	ding Physiclen: h. After this certific funeral director,		27. Manuar of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Tin ear) inju	ıry	c. Injury at work?		28d. Describe h	ow injury occurr	edi	
Sior	Attending Physicien: or death. ector: After this certific by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm	M street factory	1 🗆 Yes		28f Location (9	Street and Numb	er or Pural	Poute Number
Division of Vital	pital or Attendours efter deatlerel Director: filled in by the		4 ☐ Homicide determined	building, etc. (S	pecify)	, oncor, ractory,		Į	City or Tow		er or ridiari	route rvaniber,
	e Hospital or Attend 124 hours efter death e Funerel Director: / letely filled in by the	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	cian: To the best of my	knowledge, de	eath occurred at	the time, date	and place, ar	nd due to the ca	ause(s) and man	ner as state	d. se(s) and manner stated
	To the Hosp within 24 ho To the Fune completely f	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier			edge, death occu		e, date and pla	ce, and due to t	he cause(s) and r	manner as st	ated.
	F≯Fö		▶ Yun	- MD		250.	1	1127		29d. Date signe	17/17	ay, rear)
	00		30. Name and address of person who con		ı (Item 23a) (Ty	pe, Print)	<i>ا دن</i> د در	, , ,			1110	
	0		Alon Daxis mr		wer 8	st. Sa	lisbu	ny,	MO	21804		
	Stat Registra		31. Date filed (Month, Day, Year) 0 6 201	2 32 Registrar's S	Signatu	park		0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ 0050 ELBERT JUI 201 20 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death KEN RIVER HOSPITAL CENT RTOWN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours Days **Director** 233-42-2372 May 15 1927 1 📈 M 2 🗆 F 85 West Virginia ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Oueen Anne's Sudlersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21668 U.S.A. 5617 Sudlersville Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status the Medical Examiner Armed Forces 1 X Yes 2 No If Yes, Give ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Trash Truck Driver Trash Hauling 8 of Health and Mental Hygie If item 27 is marked other is other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cleamon Morris Kincaid Mary Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mary Coleman 5617 Sudlersville Rd. Sudlersville, MD. 21668 (niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 Removal from State Double Creek Cemetery 7/23/12 4 Donatton 5 Chestertown, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. So
118 West Cross St. Galena, MD. 2163 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Organifailure Physician/ disease or condition resulting in death) **Medical** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HTW: DM Typo II: gout; Hx Colon (A 1988 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Hypothervoid & Kidney Disease Stage 3 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital 1 ☐ Yes 2 No ဥ 14 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work s after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral D Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Qate signed (Month, Day, Year) D0050996 20/2012

Registrar

DHMH 17 Rev 06-2011

State

100 Brown St. Chastertown MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Noil Stadlard MD

27 2012

31. Date filed (Month, Day, Year)

12-05294 Fatmata Kamara

Ple	ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
		2012	2395
Enr State	Cortificate of Dooth	Same Valley	Erm Co. Lot

		- For State	Certi	ificate of	Death			Reg. No	<u> </u>	14 4000
Physicia	ın/	Decedent's Name (First, Middle,Last)	-				2. Date of Do Month	Day	Year	3. Time of Death 1101 hrs
اedical Examiı حَــر		Fatmata Kamara 4a. Facility Name (if not institution, give street and number)		14	b. City, Town, c	r Location of	July 14,		c. County of D	
		20 Manchester Place # 201			Silver Spri				Montgome	
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last	t birthday)	If Under 1 Ye			Birth(MN	1/DD/YYYY) 9	Birthplace (State or breigr Sierra Leon
Director	İ	245-63-8067 1 M 2 X F	31	Yrs.	Months Da	ys Hours	Noven	ber	22,	West Africa
b		Usual Residence of Decedent 10a. State 10b. County	Inc City T	own or Location	on.					10d. Inside City Limits
now any				Silver						1 X Yes 2 No
Aaryland 28a-f show 1 at once.	5	Maryland Montgomery 10e. Street and Number		JIIVEI	10f. Zip Code				tizen of What	
the Ma	Director	20 Manchester Place; Apt	. 201		2090	1		Sie	rra Leo frica	one, West
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	eral	11. Marital Status 12. Was Decedent	Ever in U.S.				in? (Specify Yes or Puerto Rican, etc.)			merican Indian, Black,
or ite	Funeral	1 Yes 2	XX No	_			, 40,10 (1,041), 614,		Specify:	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	2	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con	noleted) 1		Yes 2 X N		ind of work done	16b.	Kind of Busine	
'2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or			st of working lif			С	edar Cı	reek Group
036 rithin 72 ene. rr than	E E	12th grade		Certif	ied Nur		Assistant		Home	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) Ibrahim Kamara					s Name (First, Middle 110 Co.	e, Maide nteh		
21215-(nuld be filed v Mental Hygi marked oth	To Be	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stre					State, Zip Code) 20901
MD d 2 shot tth and a 27 is 1	-1	Alex Geffrard (Husband)		20 Man	chester	Place	e;Apt.201	;Sil	ver Spi	ring,Maryland
imore, MD 2121 Pages I and 2 should be fit ment of Health and Mental I teat: If item 27 is marked or other fraumatic event,		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from St		ace of Disposi ematory or oth	tion (Name of c	emetery,	Date	200	. Location - Cit	y or Town, State
MOI Pages nent of nut: I	ı	4 Departion 5 Other Specify:	For		oln Ceme	etery	July 21,2	U Ér	entwoo	d,Maryland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If iten 27 is m injury or other traumatic.		21. Signature of Funeral Service Licensee	/			ss of Facility	R. N. Ho	rton	Сотраз	ny Morticians,
_	(23a, Part I. Enter the disease, or complicating that caused	M0142	1 Inc	. ;600 K	ennedy	Street, Nardiac or respiratory	arrest, si	Washin	Approximate Interval
Physician /Medical	ļ	failure. List only one cause on each line.								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Seizure Due to (or as a cons					, , , , , , , , , , , , , , , , , , ,			
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):				·			
	nin	cause. Enter Underlying Cause								
ed nsit	Examine	events resulting in death) Last Due to (or as a cons	equence of):							Į.
760, icate be executed physician and the burial - transit	Medical	x UNPENDED AMENDED 23	a,27 r	oer me	g930 8-	20-12	vt			
760, cate be physici he buri		IF FEMALE: 23c. If yes, outco	me of pregna	ancy	7			2	3d. Date of de	
687 certific nding se as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 ✓ Pregnant a	t time of deat	th	aldeath 3 ner (Specify)	Ectopic	pregnancy		Month Jul 15, 20	Day Year
Box 687 e death certific the attending of	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		o	let (Opcony)			33.71		
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the buring.	by P	Part II. Other significant conditions contributing to dear	h but not res	sulting in the u	nderlying cause	given in Pa				te to the cause of death? Probably 4 Unknown
S, P puires t an sign	pe						24a. W			re autopsy findings available
Cord law req has bee	Completed						au	topsy rformed	prio dea	r to completion of cause of th?
tal Rec	S				26 Pla	co of Dooth (1 ✓ Ye (Check only one)	s 2	No 1	Yes 2 No
/ital	Be	25. Was case referred to medical examiner? Hospital: 1 Inpati	ent 2 E	ER/Outpatient		-	Nursing Home 5	Resid	dence 6 🗸	Other: Scene
of V ng Phy neral c	2	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Inj (Month, Day.)	ury (28b. Time of Ir	njury 28c. In	jury at Work	? 28d. Descrit	e how it	njury occurred	
ion tendir leath. tor: A	atio	Natural 5 Pending Accident Investigation			×	Yes 2				
Division of Vital Records, pital or Attending Physician: The law requir ours after death. In all Director: After this certificate has been sifiled in by the funeral director, page 2 should the control of the control	Certification:	3 Suicide 6 Could not be determined (Specify)	njury - At hon	me, farm, stree	et, factory, office	building, etc		n (Street n, State)	and Number of	or Rural Route Number, City
lospita hours uneral		4 Homicide 29a. Certifier 4 Continue Physician To the best of n	ny knowleday	e death occur	red at the time	date and pla	ace and due to the c	ause(s)	and manner as	stated
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examiner stated	amination and	d/or investigat	ion, in my opini	on, death oc	curred at the time, da	ate and p	place, and due	to the cause(s)
F.N. S.	Me	29b. Signature and title of certifier				nse number				(Month, Day, Year)
		U-VL.			0.0	C.M.E.		Ju	ly 15, 2012	
		30. Name and address of person who completed cause of Donna M. Vincenti, MD Assistant Medi			W. Baltimo	re Street	Baltimore. MD	21223		
S	tate		ar's Signatur							
Regis		111 2 0 2012 Burn A.	Mark	CAP						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0:35 A.M. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANDRIN INPATIENT CARE ARUNDEI MONTGOMERY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. 251-70-8581 1X M 2 □ F Director Yrs 67 8/10/1944 SC or 28e-f show a notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò irel", or Items 23e o Examiner must be Funeral 3091 BRINKLEY ROAD, #T1 20748 US within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 er then "neturel", c 1 ☐ Yes 2 ☐ No Specify. BLACK If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working el Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE INSURANCE AGENT 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mentel F is marked ည CURTIS KEELS NINA HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s if Heelth item 27 TELITHA LEWIS/COMPANION 3091 BRINKLEY ROAD, #T1, TEMPLE HILLS, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pege 1 e
Depertment of H
Importent: If ite
eny Injury or otl 7-17-2012 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WALDORF, MD 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL CEMTERY POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licen 22. Name and Address of Facility 5538 MARLBORO PIKE, FORESTVILLE, MD 23a. Per 1. Effet the disease in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ 00 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The lew requires that the deeth certificete be executed burial-transit Due to (or as a consequence of) resulting in death) Last ettending physician for use as the buria Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 No cete has been signed by the page 2 should be detached 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 2 🗆 No 2 1 N 1 Yes or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical of Vital e e 26. Place of Death (Check only one) examiner's +NDILLING Other: 1 Yes 2. No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title/of certifier Date signed (Month, Day, Year) Name and address of perspn who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 820 Eleanor Kandrashoff 07 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICSMICE MEDICAL 342136414 REGIONAL Center TENINSULA If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 073-14-8652 1 M 2 X F 90 7-23-1921 New York 28a-f shov 10d. Inside City Limits State 10b. Count 10c. City, Town or Location with the Maryland r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21875 USA 8772 Lennox Drive Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 🕅 Widowed 4 □ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Johan Berggren Julia Ericson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Eric Kandrashoff - Son 29588 Stillwood Drive, Delmar, Maryland 21875 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brig. Gen William C.
Doyle Veteran Mem. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any Injury or ot 1 🛛 Burial 2 🗌 Cremation 3 🔀 Removal from State 7-13-2012 North Hanover, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Pnysician Medical resulting in death) Due to (or as a consequence of): Examiner Neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No this certificate haral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes 2 X No 1 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 Yes 2 No Director: And in by the fu death. Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

51E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO ACLE, 100 EAST CARPOLL STREET, SALISBURY, MARYLAND 21801

1201/211

State Registrar 31. Date filed (Month, Day, Year) 9 2012 32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Year Physician/ 5:34 5105 orge Medical 4a. Facility Name (if not institution, give street and number County of Death 4b. City, Town, or Location of Death **Examiner** lontgonery Wentist Hospita Park Washington 19 Koma Date of Birth 9. Birthplace (State or Foreig Social Security Numb 7. Age (In yrs. **Funeral** Hours 218-16-0744 **Director** 1 🛛 M 2 🗆 F 85 Sept. 5, 1926 Mt. Rainier, MD Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland notified at Director 28a-f 1 X Yes 2 No Prince George's College Park 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 20740 5126 Mangum Road USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? 1 № Yes 2 □ No Navy If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Examin ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates. 1944–1946 "natural" 3 X Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace Engineer Private Sector alth and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Edward Krug Sarah Edna Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i Patricia A. Krug / Daughter 5126 Mangum Road, College Park, MD 20740 other t item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important; If ite any injury or otl cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State 7/11/2012 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Leg Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition oronar Medical resulting in death) Examiner apetes Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performed After this certificate filled in by the funeral director, 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F the only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2 141 2012 VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23964 = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:20P. [™] Brij B. Kapai July 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Prince George's Silver Spring Renaissance Gardens at Riderwood Village If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 83 oct.17,1928 India 220-90-1984 Director 1 XM 2 | F Usual Residence of Decedent and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Adelphi 1 Yes 2 No |Marvland |Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20783 10407 Rutland Place 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc by 1 Never Married 2 X Married Asian 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 If Yes, Give Specify. 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Association of Elementary/Secondary (0-12) College (1-4 or 5+) Home Builders Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bhagwati Talwar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er H.C. Kapai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10407 Rutland Place Adelphi, Maryland 20783 19a. Informant's Name/Relationship (Type, Print) Leela Kapai -wife 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Cranatory 20c. Location - City or Town, State Date 7/21/2012 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Wonald WB 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. 3°111011 Ch's Immediate Cause (Final Physician/ Failure to thrive, adult disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 3 years **ASCVD** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus signed to 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been sig Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has ; autopsy perform death? 1 Yes 2 No this certificate 1 ☐ Yes 2 💢 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 412633 30. Name and address of person who completed cause of death (Item 23d) (Type, Print)

Julaine Harding, NP 3160 Gracefield Road Silver Spring, Maryland 20904

State Registrar 2 6 2012

31. Date filed (Month,

32. Registrar's Signature

12-05398 Thomas Leslie	Law	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy		ible. 20	12 239
		I- For State Registrar Certificate of Death	Reg 2. Date of Death	. No.	3. Time of Death
Physician/ Medic Exami	-	Thomas Leslie Law		Day Year 12	1344 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 62 West Water Street Smithsburg		4c. County of Dea Washington	th
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 230-46-1346 1 Months Days Hours Min.	8. Dete of Birth June 26,		Birthplace (State or Foreign Country)
ny		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d, Inside City Limits
and show a	_	Md. Washington Smithsburg	1 🔀 Yes 2 🗌		
the Maryli	Director	10e. Street and Number 62 W. Water St. 10f. Zip Code 21783	10g	Citizen of Whet Co	untry?
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "nutural", or tems 23a or 28a-f show any injury or other traumatic event, the Medical Exercites in the notified it are	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No specify: 1 Yes 2 No specify:		14. Race - Ame White, etc. While Specify:	erican Indian, Black, Lte
5 72 hours at m "n:itural	leted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of word during most of working life. DO NOT use retire during most of working life. DO NOT use retire during most of working life.		16b. Kind of Business	i/Industry
MD 21215-0036 at 2 should be filed within 7 sith and Mental Hygiene. m27 is marked other than aumatic event, the Median	Be Completed	12 Carpenter 17 Father's Name (First, Middle, Last) Preston E. Law Sr. Carpenter 18.Mother's Name (Gert	First, Middle, Mai	den Surname)	1
MD 212 2 should be h and Ments 27 is mark matic even	To B	19a. Informant's Name/Relationship (Type, Pnnt) Sandra L. Law (Wife) 19b. Mailing Address (Street and Number or R 62 W. Water St. Smiths	ural Route Number burg,Md	er, City or Town, Stel	e, Zip Code)
Baltimore, formit Pages I and Department of Healt Important: If termingury or other training or other			Date 25,	20c. Location - City Smithsb	
Balti permit. Departm Imports injury o	_	21 Signature of Funeral Service Licensee 22. Name and Address of Fecility J.L. Davis Funeral	Home 12	525 Bradb ithsburg,	ury Ave. Md. 21783
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intraoral Gunshot Wound Due to (or as a consequence of).	espiratory errest,	shock, or heart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last United Sequence of Jacobs (Disease or Jacobs Company (Disease) (Disease or Jacobs Company (Disease or Jacobs			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alther death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit.	Physician/Me	23b Was decedent pregnant in the past 12 months?	icy	Month	Dey Year
res that the signed by tr	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	o the cause of dealtr? obably 4 X Unknown
Division of Vital Records, P.O. taal or stending Physician: The law requres that the sa far death. 13 Director: After this certificate has been signed by led in by the therest director, page 2 should be deaded.	ompleted		24a. Was an autopsy perform	prior to ned? death?	
tal F	Be C	25. Wes case referred to medical examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing			
1 of Vi Img Physi After this	on: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		esidence 6 X Oth winjury occurred self	er Scene
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 X Suicide 6 Could not be determined determined (Country of the Country or Town, Sta	te) Smithsburg,	urel Roule Number, City MD 21783	
the Hosp it. hin 24 hour the Funera	ledical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and ducone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the		and manner as state	
074	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number	OME	29d. Date signed (A) July 19, 2012	, ,,
MIN	ŀ	Name and address of person who completed cause of death (item 23a)	mara ND 64	202	
St	ate	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Balti 31 Date filed (Month, Day, Year) 22 Registrer's Signature	more, MD 21	223	
Regist		JUL 27 2012 Jenera B. Jacks			
DHMH 17 Rev 1/20	01	ORIGINAL			

12-05398

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ [™]Jul 20, 2012 10:10 AM Robert Harvey Long Medical 4a. Facility Name (if not institution, give street and number) County of Death Allegany Examiner 4b. City, Town, or Location of Death Oldtown 15421 Oldtown Rd. SE Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. Date of Birtl Birthplace (State or Foreign Country)
 D **Funeral** Days Hours 213-24-7293 Nov 29:41929 1 M 2 D F 82 **Director** Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location Oldtown Director 10d. Inside City Limits MD Allegany must be notified 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21555 USA 15421 Oldtown Rd. SE "natural", or items 12. Was Decedent Ever in U.S. Arged Forces?
1 Yes 2 No Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours after death 11 Marital Status 14. Race - American Indian, Examiner Black, White, etc. by S 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 3 Divorced Completed Year or Dates other than "nature vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **IBEW Local 307** electrician Be Department of Health and Mental III Important: If item 27 is marked ott any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Pearl R. Goff ည Charles S. Long Informant's Name/Relationship (Type, Print) Norma Long Mailing Address Street and Number of Rical Route Number City of Town, State, Zip (ND) 21555 wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 7/22/2012 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) e of Funera Service 22. Name ar Scarpellif Furneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (o Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the 98 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for Day Year Pregnant at time of death signed by the ai Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Was an Were autopsy findings available prior to completion of cause of cate has by page 2 s autopsy performe death? 1 ☐ Yes 2 ☐ No 1 Yes the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 Other 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home Residence 6 Other (Specify 5 hin 24 hours after death.

the Funeral Director: After this Manner of D ath 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 \square Pending 1 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier

within To the

Registrar

(Check only one

knise.

29b. Signature and tite of certifie

filed (Month, Day, Year)

27 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

32. Registrar Signat

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

600 Memorial Ave. Ste. 203 Cumberland

29d. Date signed (Month, Day, Year)

MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 23967 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mildred Rebecca Love Physician/ 2012 J™T₩ Рм 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3909 New Haven Court A-2 Prince George's Bowie 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) **Funeral** Days Hours 578-12-3319 **Director** 1 M 2 X F 96 April 5,1916 Virginia Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director Bowie MD 1X Yes 2 No Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō event, the Medical Examiner must be Funeral USA 23a 20716 3909 New Haven Court A-2 items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) DC General Hospital Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Guy Begoon Mary F. Flory other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Mazyck/Guardian 10202 Dubarry Street, Glenn Dale, MD 20769 f Health Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or otl 1 Burial 2 X Cremation 3 Removal from State 7/9/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of F neral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Terminal Cardial Arrhythmia Onset and Death Immediate Cause (Final Physician Failure to thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Advanced Demetia weeks Chronic Bedridden State Examiner Securitially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

failure to thrive Cause (Disease or injury use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Chronic Bedridden State Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 1 Yes 24 9 Unknown neral Director: After this certificate has been signed by the effiled in by the funeral director, page 2 should be detached 9 Linknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Hospital or Attending Physician: The la 24 hours after death. Funeral Director: After this certificate h Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check within 2 To the F only one) 29b. Signature and title of certifig 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9613 Bellevue Drive, Bethesda, MD 20814 Schiffman,MD egistrar's Signature State JUL 11 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:10 PM Arthur Dorsey Lapole, Sr. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Coastal the Salisbury HOSPICE Lake WICOMI Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Director 213-20-5687 1X M 2 □ F 7/23/1926 MD 10a. State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits items 23a or 28a-f sho ler must be notified at Director 1 🗌 Yes 2 🖾 No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 Deep Channel Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist US Governement 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 Is marked မ Charles Lapole Irene Burall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Butler / daughter 284 Harbor Dr., Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Importent: If it eny Injury or o ☐ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. : 7/10/12 Millsboro, DE 21. Signature of Funeral Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MAHENANT Immediate Cause (Final disease or condition LUNG CANCER Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burlal-transit Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwirthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 N 1 Yes 2/1 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence be Other (Specify) HOS PI CAL မ 1 Tyes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at **T** ∐ Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and a non-second and a non Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAR 737 JA12041 6 Hausm 1300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month \mathbf{A}_{M} 2012 June 6:35 Ruth Bernice Lee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Arcola Health and Rehab Center Silver Spring 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Days (Month, Day, Year) 9/26/1915 Director 579-20-8644 96 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No Md Prince George's Upper Marlboro ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 20772 USA 4922 Ashford Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced Specify: **Black** the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) I and 2 should be filed within f Health and Mental Hygiene. Keypunch Operator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Morton Charlotte Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Upper Marlboro, Md Philip Gray / Grandson 4922 Ashford Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, injury or 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 6/30/12 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md 22. Name and Address of Facility Fort Lincoln Funeral 21. Signature of Funeral Service Licensee ouce. anyi 3401 Bladensburg Rd Brentwood, Md 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Matural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 5 Pending 2 No Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64624 6/28/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandeel Sharma, MD 9701 Veirs Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ML 0 3 2012 Registrar

DHMH 17 Rev 7/2009

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelibje Ink. 2 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Michael Lawren		1- For State	of Marylan		rtment of tificate of	Health and Death	Mental		Reg. No.	012 233
Physician/ Medio	al	Registrar 1. Decedent's Name (First, Middle,La Michael Girard						Date of De Month	ath Day Year	3. Time of Death 0747 hrs
LAdiii	161	4a Facility Name (if not institution, gi		er)	- 1	4b. City, Town, or L	ocation of De	July 15, 2 eath	4c. County of	Death
Ermarol		Shady Grove Hospital 5. Social Security Number 6.	Sex 7	. Age (in yrs. id		Rockville If Under 1 Year	If Under 24	Hrs. 8. Date of E	Montgome	ery 9. Birthplace (State or Foreign
Funeral Director		215 92 2602	XM 2 F	52	Yrs	Months Days		4.00	6, 1960	Country) Washington,DC
ĥυ		Usual Residence of Decedent 10a. Stata 10b. County	-	10c, City,	Town or Locat	on				10d. Inside City Limits
Maryland 28a-f show any d at once.	_	Maryland Anne A	rundel	G	Glen Bu	rnie				1 XYes 2 No
Maryla	Director	10e. Street and Number	_			10f. Zip Code	260		10g. Crtizen of Whet	Country?
with the		452 Renfro Cour 11 Marital Status	12. Was Dece	dent Ever in U.S	S. 13. Wa	210 as Decedent of Hisp		Specify Yes or N	USA o- 14. Race - 4	American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho injury or other traumatte event, the Medical Eartman be noulffed at once.	y Funeral	1 Never Married 2 Married 3 Widowed 4 X Divorce	Armed For 1 Yes	ces? 2 X No		es, specify Cuban,		etc. White		
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036 ithin 72 me r than "	Completed	Elementary/Secondary (0-12)	College (1-4	or5+)	Auto	Mechanio	2		Automo	bile
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If tern 27 is marked other than injury or other traumatte event, Inc. The leas	Be Co	17 Father's Name (First, Middle, Lass Richard F. Lawr				1:			Maiden Surname) erine Bli	gh
D 21; should b and Men 7 is mar	10	19a. Informant's Name/Relationship (* John B. Lawrenc		har	19b. Meiling	Address (Street Beall Roa			mber, City or Town,	State, Zip Code)
e, M 1 and 2 Health : trem 2		20a. Method of Disposition		20b. F		ition (Name of ceme		Date Date	20c. Location - C	ity or Town, State
imor Pages nent of ant: If or othe		1 X Burial 2 Cremetion 3 4 Donation 5 Other Speci	fy	Otate	e of Hea	even Cemete	- ,	/21/2012	Silver S	ring,Maryland
Balt permit. Departu Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimo Gasch's Funeral Home, P.A. Hyattsville,								ltimore Avenue ille, MD 2078]
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on	plications that caus	sed the death, (-	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Alcohol Due to (or as a c			(free mor	phine)	Intoxica	ation	Death
4	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of	`):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c							
executed an and al - transit			d.			0 6		25 1 0 1	2	
'60, rate be exc obysician he burial -	Medical	IF FEMALE:	28e, per	me,g93	5 1-25	8a-f,per -13 sm	me,g9	35 1-9-1	3 sm 23d. Date of de	ilvery
Box 68760, e death certificate be executed the attending physician and led for use as the burial - transit		23b Was decedent pregnant in the past 12 months?	1 Live birt		2 Fe	tal death 3	Ectopic pre	gnancy	Month	Dey Year
Box e death the atter	Physician/	1 Yes 2 No 9 Unknow	vn 9 Unknow	n	3 🗌 0	her (Specify)				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending prompiletaly filled in by the funeral director, page 2 should be detached for use as the compiletaly filled in by the funeral director, page 2 should be detached for use as the compiletaly filled in by the funeral director, page 2 should be detached for use as the compiletaly filled in by the funeral director, page 2 should be detached for use as the compiletaly filled in by the funeral director, page 2 should be detached for use as the compiletaly filled in by the funeral director, page 2 should be detached for use as the compiletal filled in by the funeral director.		Part II. Other significant conditions Cocaine Use, Ch	-		•	derlying cause give rtensive	in in Part I.			te to the cause of death? Probably 4 X Unknown
ords, w requir	Completed by	Atheroscleroti							ppsy prie	re autopsy findings available or to completion of cause of
i of Vital Records ing Physician: The law requ After this certificate has been tuneral director, page 2 should	Com					20.5	(5)	1 X Yes		ath? Yes 2 No
Vital ysician: his certi	To Be	25 Was case referred to medical examiner? 1 X Yes 2 No	Hospital. 1 In	patient 2 X	ER/Outpatient		of Death (Che other 4 Nu	rsing Home 5	Residence 6	Other
n of Jing Ph After ti funeral		27 Manner of Deeth 1 Natural 5 Pending		Injury Day,Year)	28b. Time of I	100	at Work?	28d. Describe	how injury occurred	
Matural Specify Spec							(Street end Number o	or Rurel Route Number, City		
Div	Cert	4 Homicide determin	ned (Specity)		known.			Gaithe	rsburg,MD	
Division of Vital Reco To the Hospital or Attending Physician: The la within 24 hours after death. To the Puneral Director: After this certificate ha completely filled in by the funeral director, page 2	Medical		er: On the basis of	examination an					e(s) and manner as s and place, and due to	
To	Me	29b. Signature and little of certifier	and manner sta	eu.		29c. License	O	CME		(Month, Day, Year)
		30 Name and address of person who	11 K	19 J	2 My), O.C.N	1.E.		July 16, 20	12
		Theodore M. King, Jr., M	D. Assistant	Medical Ex		000 W. Baltimor	re Street, E	Baltimore, MD	21223	
St	ate	31. Date filed (Month, Day Year) 12	32 Reg	strer's Signatur	perko	1				

12-05333 Donald Ray Leizear

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 2397	2	0	and designation of	2	2	3	9	7
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		I- For State Registrar	Certifica	ate of De	eath		Re	g. No.		
Physici	an/	Decedent's Name (First, Middle,Last)					Date of Deat Month	h Day Year	3. Time of Death	
ledical Exam	iner	Donald Ray Leizea					July 16, 20)12	0747 hrs	
		 Facility Name (if not institution, give st 14021 Pleasant View Drive 	reet and number)		city, Town, or Lo owie	f Death eorge's				
Funeral Director		5. Social Security Number 6. Sex 217-06-1127	7. Age (In yrs. last birt	M	Under 1 Year fonths Days	If Under 24Hrs Hours Min	_	h(MM/DD/YYYY) 16, 1976	9. Birthplace (State or Foreign Cheverly, Country) Maryland	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				August	10, 1570	10d. Inside City Limits	
Maryland 28a-f show d at once.	ğ	Maryland Prince Geo	orge's Bov		7:- 0-4-			a Citizen of Mar	1 X Yes 2 No	
the Mary 3a or 28a	Director	10e. Street and Number 14021 Pleasant Vi	ew Drive	101	f. Zip Code 2072	0		Og. Citizen of What Country? USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannell Hygiers. In them 77 is marked other than "natural", or items 23a, or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married 1	2. Was Decedent Ever in U.S. Armed Forces? Yes 2 X No	If Yes, s	cedent of Hispa specify Cuban, M	fexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - White,	- American Indian, Black, etc. White	
urs afte tural", eminer	d by	3 Widowed 4 Divorced If Nor 15. Decedent's Education (Specify only I	Dates: nighest grade completed) 16a.	Decedent's U	sual Occupation	(Give kind of	work done	16b. Kind of Bus	iness/Industry	
D36 thin 72 horner. rthan "naicedical Exi	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	red)	Glass	Industry				
15-0(iled wi Hygier d other		17. Father's Name (First, Middle, Last)		*			(First, Middle, Market)	Maiden Surname)		
21215-0036 ruld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	John Lloyd Leizea 19a. Informant's Name/Relationship (Type		b. Mailing Add					n, State, Zip Code)	
MD d 2 shorth and and 27 is numation		Linda M. Freidlin					Bowie, M			
ore, es l and of Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State cremat	ory or other p		· ·	Date		City or Town, State	
Baltimore, bermit. Pages I ar Department of Hes Important: If ite njury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			n Cemete				ood, Maryland	
Bal permi Depar Impo injur		- Sarela AAn Royer	·	Gascl	n's Fune	eral Ho	me, P.A.	Hyattsvi	timore Avenue 11e, MD 20781	
Physician Medical		23a. Part I. Eifter the disease, or complica failure. List only one cause on each	line.				r respiratory arre	est, shock, or hea	Between Onset and	
xaminer			e to (or as a consequence of):	ie) Int	oxicati	on			Death	
		Sequentially list conditions, b.	7.5 (5) 45 45 51.55 425.155 57							
	niner	cause Enter Underlying Cause	e to (or as a consequence of):							
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of):	- .		-				
760, ficate be executed g physician and the burial - transit	edical	X UNPENDED a.	MENDED 23a, 27, 28a-	f,per	me,g930	8-13-	l2 sm			
'60, ate be physici he buri	Med		23c. If yes, outcome of pregnancy					23d. Date of o		
Box 68760, he death certificate be the attending physic hed for use as the bur	Physician/	A D Mar o D Mar o D Mal agree I	1 Live birth 2 4 Pregnant at time of death 9 Unknown	=	eath 3(Specify)	Ectopic pregna	ancy	Month	Day Year	
b.O. B that the de ned by the detached f		Part II. Other significant conditions co		g in the under	rlying cause give	en in Part I.			oute to the cause of death?	
S, P.O. uires that the signed by	ed by								Probably 4 Unknown	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death, certif within 24 hours after death, Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was autop perfor 1 Yes	sy pr m <u>ed</u> ? de	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	pital: 1 Innetiont 3 EP/O			Death (Check				
f Vir Physic er this eral dir	유	1 ✓ Yes 2 No 27. Manner of Death	I Inpatient 2 LRO	utpatient 3				Residence 6		
on of ending Phath.	tion:	1 Natural 5 Pending	(Month, Day, Year)	7:28 a	1 7	s 2 🗶 No	unknown			
Division pital or Attendio ours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for (Specify) found at h	arm, street, fa		lding, etc.	or Town, S		er or Rural Route Number, City Pleasant View	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On	To the best of my knowledge, denthe basis of examination and/or i	ath occurred			due to the caus	e(s) and manner		
To with	Me	29b. Signature and title of certifier	d manner stated.		29c. License r	number		29d. Date signe	ed (Month, Day, Year)	
		0-201			O.C.M.	.E.		July 17, 20	12	
		30. Name and address of person who com Donna M. Vincenti, MD As	ppleted cause of death (Item 23a) ssistant Medical Examiner	900 W	Baltimore S	Street. Baltir	nore. MD 21	223		
	tate	31. Date filed (Month) Pay Year 1		ake						
Regis		and vall	Chow b. 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LUCA5 Month ANDON ELLIOTI 0048 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** CHEVERLY PRINCE GEORGE'S HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 220-19-8898 Months Hours Min. (Month, Day, Year) Director 1 **X** M 2 □ F 27 MD LINE 28a-f shov 10c. City, Town or Location aţ 10a, State 10b. County 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified 1 X Yes 2 ☐ No BOWIE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral US 20721 1607 MONARCH BIRCH WAY items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE CUSTOMER SERVICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ BRYNDA LUCAS CHESTER MAURICE TOLIVER 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 MONARCH BIRCH WAY, BOWIE, MD 20721 BRYNDA LUCAS/MOTHER 20a. Method of Disposition 1 😾 Burial 2 🖸 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important; If ite any injury or of HARMONY MEMORIAL PARK 7-13-12 LANDOVER, MD Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21, Signature of Funeral Service Licensee once. 18700M 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or compli ns that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only o Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine IMMUNODEFICIENCY Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical certificate be 68760 the as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box (Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No cate 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes death. Accident Suicide Investigation 24 hours after death Funeral Director, 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 29b. Signature and title of certifie 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL CAPEVENIS , MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	Maryland / I	Department of H Certificate of D			0.0	10 00070		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	Jeain	Reg. 2. Date of Death	. No.	3. Time of Death		
L	Physicia Medic		M. Dianne Morris				$J_{\mathbf{u}}^{Month} 5, 2$	2012 Y	10:05P M		
A Salar	Examin		4a. Facility Name (if not institution, give street and number Anne Arundel Medical Cent		4b. City, Town, or Annapol	Location of Death		4c. County of Anne A			
- 18 C	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birt	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	. Birthplace (State or Foreign		
6	Director		215-38-4694 Usual Residence of Decedent	70	Yrs. Months Days	Hours Min.	(Month, Day, Yea 8/10/194)		ashington, DC		
	land show dat	tor	10a. State 10b. County	10c. City, Tow	n or Location		-7 - 37 - 27 1.		10d. Inside City Limits		
	e Mary r 28a-1 notifie	Direc	Maryland Anne Arundel	Edgewa	10f. Zip Code		1 ☐ Yes				
	with th	Funeral Director	4196 Carvel Lane		21037		109.	USA	at Country?		
980	is filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show of other, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced 12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Dates	X No	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto F		Black, \	American Indian, White, etc. White		
21215-0036	nin 72 hou ne. han "nat u e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) Oan Officer		b. Kind of Busir	ness/Industry			
d 21	filed within 72 al Hygiene. d other than '	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	Banking den Surname)					
ylan	ild be file Mental narked c	မ	Arthur Clifton Madison				rnette Ge				
Maryland	1 and 2 should be fi f Health and Mental item 27 is marked other traumatic ev	W	19a. Informant's Name/Relationship (Type, Print) William E. Morris/Husband		o. Mailing Address (Street a				e, Zip Code)		
ore,	1 and of Heal item?		20a. Method of Disposition	20b. Place o	of Disposition (Name of ery, crematory or other place				ty or Town, State		
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.		1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	ate	Crematory	July8		lgewater			
Bal	permit. Departr Import. any inji	Į,	21. Signatur & Funeral Service Licensee	7	22. Name and Address 2973 Solome	ons Islan	d Rd., Ed				
ا م	hysician/		23a. Part 1. Enter the disease, of complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	sed the death. Do r line.	pan cveati	g, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death		
-	Medical Examiner		resulting in death) Due to (or	as a consequence	of):				7 77 77		
		iner		as a consequence	of):						
	scuted and -transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or	as a consequence	oft						
0	cate be executed physician and the burial-transit	edical E	d d	as a consequence	o.,						
	tificate ng phy as the	Medi	IF FEMALE:					T			
). Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death within 24 hours after death contributed to the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcor	th 2 Fetal death nt at time of death	h 3	у	1	23d. Date o Month			
ds, P.O.	requires that been signed k should be det	by	Part II. Other significant conditions contributing to deat	h but not resulting	in the underlying cause give	en in Part I.	23e. Did tobaco		te to the cause of death?		
Division of Vital Records,	: The law re cate has be ; page 2 sh	Completed					24a. Was an autopsy performed	prio dea	re autopsy findings available or to completion of cause of th? Yes 2 No		
/ital	rsician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital:	patient 2 FR/O	26. Pla utpatient 3 □ DOA	ace of Death (Check	only one) ne $5 \square$ Residence	a 6 Other /	Energify)		
of	ding Phys th. After this funeral di		27. Manner of Death 28a. Date of i	njury 28b.	Time of 28c. Injury work?	at 2	8d. Describe how in		россиу)		
sion	Attendi death ctor: A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Injury - At home, fa	M 1 1	Yes 2 ☐ No	 28f. Location /Street	t and Number o	r Rural Route Number,		
Divi	tal or / irs after al Dire			etc. (Specify)			City or Town, St				
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of Certifying Nurse Practitioner: To	of examination and/o	or investigation, in my opinio	n, death occurred at	the time, date and pl	lace, and due to	the cause(s) and manner stated.		
	To th comp	_	29b. Signature and title of certifier 4. ** ** ** ** ** ** ** ** ** ** ** ** **		29c. License				fonth, Day, Year)		
	7/2		30. Name and address of person who completed cause of		(Type, Print)	1808		T10/2			
<u> </u>	Y. U		Stuart E. Selonick, M	10 200	03 Medical	Pavkwav	Anna	apolis,	Md. 21401		
÷	Stat Registra		31. Date filed (Month, Day, Year) JUL 0 9 2012 32. Ref	strar's Signature	pare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Delores McGutharie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 9. Birthplace (State or Foreign Country)
DC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5-20-1939 . Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🗚 F Min. Hours 73 Director 578-52-8284 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~ ^ 00 - 1 any injury or other traumatic contents. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ¥ Yes 2 □ No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20011 3822 5th Street NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🗓 No 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify: Black Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DC Government Clerk 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Smith William Howerton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 5th Street, NW Doris Coram/Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State July 13,2012Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service License 4217 Ninth Street, NW Washington, DC art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Atherosclerati (STONASY AT RIY Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 1 Ves 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) iniurv 1 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

12-05087 Alvin Darris Melvin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 23975

		- For State Certificate of D	Death		g. No.	
Physicia	_	1. Decedent's Name (First, Middle,Last)		Date of Death Month	h Day Year	3. Time of Death
edical Examin		Alvin Darris Melvin		July 6, 201		2047 hrs
and i			City, Town, or Location of Death		4c. County of Death	
			Princess Anne		Somerset	_
	-		If Under 1 Year If Under 24Hrs.	8 Date of Birt	h(MM/DD/YYYY) 9. Birth	place (State or
Funeral			Months Days Hours Min.		Foreign	
Director	- 10	069-66-8702 1XM 2 F 45 Yrs.		12-26	–1966 ^{Cour}	ntry]NY
	ı	Usual Residence of Decedent				
any	ı	10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
	. I	MD Somerset Princess A	nne			1 XYes 2 No
daryland 28a-f show	ᅙ		10f. Zip Code	10	Dg. Citizen of What Count	rv?
Mar 28a	Director	Toe. Street and Number				.,.
th the Maryland 23a or 28a-f sho notified at once	ןֿבֿ	12460 Somerset Avenue	21853		USA	
with with be no	-	4 15 0	Decedent of Hispanic Origin? (Sp , specify Cuban, Mexican, Puerto		14. Race - America White, etc.	an Indian, Black,
eath iter	ĔΙ	1 Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 X No	, specify cuball, Mexicall, Fuelto	rtican, etc.)		
ter d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes	es 2X No specify:		Specif Black	
hours at natural	<u></u>		Usual Occupation (Give kind of w		16b. Kind of Business/In-	dustry
2 hou	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life. DO NOT use retir	ed)		
5-0036 led within 72 Hygiene.	픫		tion Worker		Mountaire	Farms
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First Middle N		2 0 2 1 1 1 2
the detail	ပ္	•			,	
12 ental	Be B	Herman Melvin	Lovie		O' T Ot-t-	7:- 0
21 nould bend Men is mar	ို		ddress (Street and Number or R			
MD id 2 shoulth and in 27 is aumati	- L		Somerset Ave			
Heal and		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	on (Name of cemetery,	Date	20c. Location - City or T	own, State
TOT ages at of tr. If of other	-1	_ Chring Hil	Gard 7_1	4-2012	Hebron,	MD I
t. P. tme	H	4 Donation 5 Other Specify: PPT III9 RT I 21. Signature of Funeral Service Licensee 22. Nam	me and Address of Facility 91	7 W T	cabella St	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f shu injury or other tranmatic event, the Medical Examiner must be notified at once	4	Ben	nnie Smith	/ W • ±	MD 2100	11
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	neral Home Sa	I 1 S D U I	y MD ZIOU	Approximate Interval
Physician		failure. List only one cause on each line.	mode of dying, sacras cardiae of	respiratory arre	or, bridging of floure	Between Onset and
/Medicar Examiner	-1	Immediate Cause (Final disease a. Intra-Oral Gunshot Wound				Death
C.XaiiiiiiGi	- 1	or condition resulting in death) Due to (or as a consequence of):				
	.	Sequentially list conditions, b.				
	힐	if any, leading to immediate Due to (or as a consequence of):				
		(Disease or injury that initiated				
ed sit	اق	events resulting in deathy East				
and and		d		·		
3760, ficate be executed g physician and s the burial - transit	/Medical	UNPENDED				
3760, Ificate be ig physici	š I	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	. 🗀		23d. Date of delivery	
	E (past 12 months?		ncy	Month Da	ay Year
Box 68 e death certil the attending ed for use as	띯	A Viv. o No. o Ulabrassa	(Specify)			
Box 687 re death certific the attending I	Physiciar	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	Latin come di caria Dadi.	220 Did to	bacco use contribute to the	ne cause of death?
P.O. B		Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.			
p. P.C	흵			1 Yes	2 V No 3 Proba	ably 4 Unknown
ords v requir s been should	Completed			24a. Was autop		opsy findings available ompletion of cause of
law r has t	힐			perfor	med? death?	
The cate	팃			1 Yes	2 No 1 Yes	2 No
	8	25. Was case referred to medical examiner?	26 Place of Death (Check			
Vici direc	삥	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	3 DOA Other Nursin	g Home 5	Residence 6 🗸 Other:	Scene
ing Ph	r r	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	ury 28c. Injury at Work?		now injury occurred	
th. A refu	.호	1 Natural 5 Pending Jul 6, 2012, Year) 2046 hrs	1 Yes 2 ✔ No	Subject sho	l Sell	
Sic Atte	g	2 Accident Investigation 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (5	Street and Number or Run	al Route Number, City
afte Dir	Certification:	3 ✓ Suicide 6 Could not be	_	or Town, S Rt 13 North B	itate) ound, Princess Anne,	MD
Spits hours	ပ္ပ	4 Homicide	CONC			
e Ho c Fu e Fu	ह	(Check only	ed at the time, date and place, and	due to the caus	se(s) and manner as state and place, and due to the	d cause(s)
omp	Medical	and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		M. 1/t	O.C.M.E.		July 8, 2012	
210	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
510		Jack Titus MD. Deputy Chief Medical Examiner 900 W. Ba	altimore Street, Baltimore	MD 21223		
Sta Regist	ate	31. Date filed (Month, Day, Year) 12. Registrar's Signature	1			
Regist	للنة					
DHMH 17 Rev 1/20	001	ÖRIGINAL			DOME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 857PN Gerald W. Mills Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Lanham <u>Prince Georges</u> If Unde Hours 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) **Director** 216-94-3343 1 🔀 M 2 🗆 F Feb. 10, 1966 MD Usual Residence of Decedent 46 "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director 1 X Yes 2 No MD PGBowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13215 10th Street United States 20715 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married Yes f Yes, Give 2 No 1 Yes 2 No Specify. Specify: 3 Widowed 4 X Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Private Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DeLanta Mills Alice Briley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13215 10th Street
Bowie MD 20715 Alice Mills/Mother Bowie, MD 2

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7/13/12 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nat Harmony Mem. Park Landover, MD 21. Sign ur of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failu Immediate Cause (Final ock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or s a consequence Examiner hereta Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to complet on of cause of autopsy performed death? Areousers (erebro 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After the prompletely filled in by the funer 5 Pending work? 2 🗆 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ver a Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3) Form, ing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Unly one) ignature and t

State Registrar

DHMH 17 Rev 06-2011

Name and address of person who completed cause of death (Item 23a) (Type, Print) huckld., Lanham,

D70967

riease	Type or Print in Black Indelig	de ink.	Ensure	All Copie	es Are	Legibl
	State of Maryland / Departme					

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C. U	- 6	6-	6	J	1	- 1	- 1

			e of Death	Reg. N	40 L	4 4091
Physic				2. Date of Death Month Da		3. Time of Death
Medical Exam	iine	THIS THE THOUSE		July 15, 2012		0050 hrs
<i>}</i>		4a. Facility Name (if not institution, give street and number) 1218 Oates Street	4b. City, Town, or Location of Dea Fairmont Heights	ith	4c. County of Death Prince George'	
Funera	1	Social Security Number		re 9 Date of Birth (84	_	
Director		577-08-8863 1XM 2 F 30	Months Days Hours M	in. 10-13-15	M/DD/YYYY) 9. Birth Foreign Coul	place (State or
		Usual Residence of Decedent	Yrs.	10/31/1	701 Cou	ntry) DC
any		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
Aaryland 28a-f show Lat once.	5	MD PG FORESTVI	LLE			1 X Yes 2 No
Aaryla 28a-f 1atol	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Count	y?
th the Maryland 23a or 28a-f sho notified at once	듑	2505 BOONES LANE	20747	,	JS	
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1.	Was Decedent of Hispanic Origin? ()	Specify Yes or No-	14. Race - America	an Indian, Black,
r deat nr ite	∄	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	A CITZ
s afte	<u>a</u>		1 Yes 2 X No specify:		Specify: BL	ACK
5-0036 led within 72 hours tygiene. other than "natur the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	pedent's Usual Occupation (Give kind of ing most of working life. DO NOT use re	work done 16b	Kind of Business/Inc	lustry
hin 7. than than	age	12TH TEC	HNICIAN		DDTWAME	
5-00 led wit Hygien other	등	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	PRIVATE	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	WILLIAM B. MCCOY		STUCKEY	ariamo,	
ID 21 should and Me 77 is man	ုင္	19a. Informant's Name/Relationship (Type, Print) 19b. N	ailing Address (Street and Number or		City or Town, State, 2	(ip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers the matural", ur items 23a or 23a-fabt traumatic event, the Medical Exambler must be notified at once		ANNIE MILBOURNE/MOTHER 25	05 BOONES LANE, FOR	ESTVILLE,	MD 20747	
Baitimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury on other traumat			sposition (Name of cemetery, or other place)		. Location - City or To	· .
imo Page ment c			COLN CEMETERY JUL	Y 28,2012B	RENTWOOD,	MD
Salt ermit. eparti npor		21. Signature of Funeral Service Licensee MOO981	22. Name and Address of Facility PO			
	11 2	Charles E. Mung	5538 MARLBORO PIK	E, FORESTVI	LLE, MD 20)747
Physician / Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause of each line.	iter the mode of dying, such as cardiac	or respiratory arrest, st	hock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Traumatic Asphyxia Due to (or as a consequence of):				Death
*		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
1760, ficate be executed g physician and the burial - transit		d.				
e exercian a	/Medical	X UNPENDED XXAMENDED 23a, 27, 28a-f,	per me,g930 8-1-1:	2 sm		
1760, ficate be g physici the buri	₩.	IF FEMALE: 23b. Was decedent pregnant in the	,9/25/2012, WS/ #3 ₁	orFH, 932, 10	3d. Date of delivery	
68 certifi nding se as		past 12 months?	Fetal death 3 Ectopic pregna	and the second s	Month Day	Year
Box 68 death certifule attending	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			ļ
rres that the death certification is signed by the attending the detached for use as		Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
of Vital Records, P.O. og Physician: The law requires that the office that the office has been signed by meral director, page 2 should be detach	d by			1 Yes 2	✓ No 3 Probab	ly 4 Unknown
Cords, law requir has been s	Completed			24a. Was an		sy findings available
(ecol	틹			autopsy performed?	death?	pletion of cause of
tal Rec cian: The certificate ector, page	Be	25. Was case referred to medical	26.Place of Death (Check	only one)	Yes 1 Yes	2 No
Vit.	` o	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other		ence 6 🗸 Other: Se	cene
n of ding Ph. After t		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how inj	jury occurred sub	jeçt struck
sion trend death. ctor:	aţi	1 Natural 5 Pending Pending fd 7-15-12 fd 12		and pinned attempted	robbery	r during
Division pital or Attendii ours after death. teral Director: A	Certification	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (Street a	and Number or Rural	Route Number, City
ospita hours ineral		4 Nomicide determined (Specify) Roadway		or Town, State)] Fairmount		ot.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	check only one) 2 Medical Examiner: On the basis of examination and/or inves	courred at the time, date and place, and	due to the cause(s) ar	nd manner as stated.) (2)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number			
	_	0-7).	O.C.M.E.		Date signed (Month,	Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	J.J.IVI.L.	July	y 15, 2012 —————	
			00 W. Baltimore Street, Baltin	nore, MD 21223		
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	<u>//</u>			
Regist	rar	JULE UZUIZ CAME A. MANO				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) Date of Death Day Physician/ 7/6/201 2:30A Medical 4a Facility Name (if not institution, give street and number) wn, or Location of Death 4c. County of Death 4b. City **Examiner** 4005 Forestville Rd. Forestville Prince George's If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number Funeral 1 🛛 M 2 🗆 F Months Days Hours Min. (Month, Day, Year, Yrs. 79 Director 425-50-0207 8. Carrollton. MS Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Funeral Director 1X Yes 2 No Forestville MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4005 Forestville Rd. 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. . 0. Completed by 1 Never Married 2 Narried 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Flementary/Seconday (0-12) College (1-4 or 5+) Public Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever ပ George Montgomery Dora Day Kimburgh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Forestville Rd. Forestville, MD 20747 Doris Montgomery/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 7/13/2012 Cheltenham, MD MD 22. Name and Address of Facility Johnson & Jenkins Funeral Home Signature of Funeral Service Licenses 716 Kennedy St. N.W. Washington, DC 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atrial Fibillation disease or condition resulting in death) Medical Due to (or as a consequence of):

Cardiomyopathy Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death the detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure, Hypertension, Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? Yes 2 No 1 Yes 2 No certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Phr within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could ngt be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner. On the best of examination and on involuded at the time, date and place, and due to the cause(s) and manner as stated.

1 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signat aus D00030296 MD 7/10/12

State Registrar 5100 Auth Way Suitland, MD 20746

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Mark

Deborah Thompson,

Date filed (Month, Day, Year)

1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 23979
State of Maryland / Department of Health and Mental Hygiene

Maurice Nathan	Ма	1- For State Certificate of Death	
Physici	ian/	Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death 3. Time of Death
Medical Exam	iner	Maurice Nathan Mason	July 6, 2012 Year 1550 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 6411 Riggs Road Hyattsville	th 4c. County of Death Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	
Director		579-66-0602 1 X M 2 F 62 Yrs. Months Days Hours Mir	
		Usual Residence of Decedent	August 7,1949 D. C.
r any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
and f shov	ō	District of Columbia Washington	1 X Yes 2 No
ne Maryland or 28a-f show fied at.once.	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ith the 23a o notifi	al D	5732 - 2nd Street, N. E.; Apt. 1 20011 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	United States Specify Yes or No- 14. Race - American Indian, Black,
ath wi items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	
fter de [", or	y Fu	1 Yes 2 X No 3 Widowed 4 X Divorced II Yes, Give Year 1 Yes 2 X No specify:	Specify: Black
ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref	
6 172 h an "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	·
003 within giene. her th	E	11th grade Independent Truck Driv. 17. Father's Name (First, Middle, Last) Is. Mother's Name.	ver Trucking Company ne (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Hugh Mason Glori	
212 ould be Ment marric	To E	19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or	
MD ad 2 sho lith and an 27 is		· · · · · · · · · · · · · · · · · · ·	ple Hills,Maryland 20748
_ 5 % 5 6		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jul	Date 20c. Location - City or Town, State 1y 20,2012
Baltimore, permit. Pages 1 a Department of He important: If it it in jury or other t		4 Donation 5 Other Specify: National Harmony Memorial	
Salt ermit. Departi mport		all IIII (DINETE	N. Horton Company Morticians
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Street, N. W.; Washington, D. C. 200 or respiratory arrest, shock, or heart Approximate Interval
Physician Medical		failure. List only one cause on each line.	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Compile or condition resulting in death) Due to (or as a consequence of):	ilicated by Hyperthermia
	١. ا	Sequentially list conditions, b	
	ineı	if any, leading to immediate Cause. Enter Underlying Cause Due to (or as a consequence of):	
	хаш	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):	
50, te be executed sysician and burial - transit	edical Examiner	d	
O, be ex sician	edic	UNPENDED	
Records, P.O. Box 6876 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the t	M/u	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery nancy Month Day Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
. Bo he dea trhe a	hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.O.	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate cancer	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death as after death. The The The Properties of the After this certificate has been signed by the atterled in by the funeral director, page 2 should be detached for u	ted	1 Tostate Gallion	24a. Was an 24b. Were autopsy findings available
COFC law re has be	Completed		autopsy pnor to completion of cause of death?
Re The ficate		25. Was case referred to medical 26.Place of Death (Check	1 ✓ Yes 2 No 1 ✓ Yes 2 No
lital sician is certi	Be	examiner? [Hospital: 4 Investigat 3 Investigat 3 DOA JOther, Alices	sing Home 5 Residence 6 🗸 Other: Scene
of V g Phy fter th	ļ.	27 Manner of Death 28a Date of Injury 28h Time of Injury 128c Injury at Work?	28d. Describe how injury occurred
OD cath.	텵	Townstration Natural 5 Pending FOUND: Poury Pear) Pound: FOUND: 1 Yes 2 No No 1 Yes 2 No No 2 Accident Investigation Investigation 1 1 Yes 2 No	Subject exposed to high environmnetal temperatures
VISI or Att fter de Direct	ij.	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. The the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	4 Homicide determined (Specify) Parking Lot	or Town, State) 6411 Riggs Road, Hyattsville, MD
e Hos 1 24 hα e Fun letely 1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	
To th withir To th compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 2000 29c. License number	
	≥	29b. Signature and title of certifier O.C.M.E.	July 7, 2012
7		My Canty, Me	Odiy 7, 2012
4		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 21223
s	tate	31 Date filed (Month, Day Year) 32 Registrar's Signature	
Regis		JUL 1 1 2012 Janes B. Janes	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elena Diana Maloney 2:29A M 5,2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours Min 103-34-3413 Director 1 □ M 2 🛛 F 91 December 5, 1920 Panama 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ems 23a or 28a-f sh r must be notified a Maryland Prince George's Greenbelt 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 8007 Mandan Road, #201 20770 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give かoned, たler Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 🛮 Yes 2 🗆 No Specify: Panamanian Specify: **Black** Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health & Hospital Elementary/Secondary (0-12) 12 College (1-4 or 5+) Corporation Dietary Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. Joseph Davis Rebecca Carlyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie R. Maloney/ Daughter 8007 Mandan Road, #201, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 7/16/2012 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on such line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No 1 ☐ Yes 2 € To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 0 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the pasis of examination and on investigation, in this operation date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier α aws 315h D6363 07-05-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishaw 8118 Good MID. hack Rd. MD. 20706 , Lanham, Date filed (Month, Day, Ye State Registrar

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Raymond Charles	1	ameron Mixooke S	ate c	f Maryla		epartm <i>Certific</i>				Menta	al Hy		Reg. No		0	2 2398
Physician	7	Decedent's Name (First, Midd	le,Last)	Raymor	nd Ch	arles	cam	eron	Mixs	sooke	2	2. Date of De		Year		3. Time of Death
Medical Examine				harles M		<u>e-</u>						Month July 5, 20				0156 hrs
	1	4a. Facility Name (if not institution							Town, or L Burnie	ocation of	Death			c. County of Anne Art		
	4	Baltimore Washingto	6. Sex			yrs. last bir	thday)		er 1 Year	If Under	24Hrs	8 Date of F				nplace (State or
Funeral Director		5. Social Security Number				-		Month		Hours	Min.	1			Foreign	1
Director	L	574 80 4200	1 XX	1 2 F		26	Yrs			L		Oct 1	2, 1	985	Cor	^{intry)} Alaska
\$u\$		Usual Residence of Decedent 10a. State 10b. County			100	. City, Town	or Locati	ion							· T	10d. Inside City Limits
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yland F-f sh		Alaska Pen 10e, Street and Number	шыш					10f. Zip	Code				10g. Cit	tizen of Wh	at Coun	try?
the Maryland i or 28a-f sh	ě	1076 Walnut Ave						l '		7000				U.S.A.		
ith th		11. Marital Status		12. Was Dece	edent Eve	r in U.S.	13. Wa	s Decede		L-7208 anic Origii		cify Yes or N	lo-			can Indian, Black,
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fter de		3 Widowed 4 Di	orced II	1XX Yes Yes, Give Year	Acti	ve Duty	1 🗌	Yes 2	No	specify:						American
ntural amin	9 -	15. Decedent's Education (Spe		or Dates.			Deceden		Occupation				16b.	Kind of Bus	siness/Ir	ndustry Indian
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21215-0036 Juld be filed within 7 Mental Hygiene Revent, the Media		17. Father's Name (First, Middle							18			First, Middle				
121 d be fi ental arkec	8	Reuber 19a, Informant's Name/Relation		Mixsooke		140	h Mailie	- A al al a a a a	(0)			G. (un			Ctoto	Zin Codo)
Should Should Miles in Miles i	٩Г	Samantha A.Mixsox				18			•					•	i, State,	Zip Code)
MD and 2 sho salth and cm 27 is	ŀ	20a. Method of Disposition	же (wite)		20b. Place						aska 9 _{Date}	9011- 20c.	Location -	City or	Fown, State
Ore of He if its		1 X Burial 2 Crematio	n 3 🗌	Removal fro	m State	crema	tory or off	her place	1		Ъ.1	11/1 OC	110-			
Lim Pag ment tant:	Ļ	4 Donation 5 Other S				Una	lakle	et Vi	11age	Cemeto	ery_	-y14, 2C	TPUN	alakle	et, A	laska Old Alexandri
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	-	21. Signature of Funeral Service	License	1			22. N	lame and	Address	of Facility	Lee F	uneral	Ho.ne	,Inc. 6	6633	Old Alexandri
	4	28a. Part I. Enter the disease, o	complic	cations that ca	0257 used the	death. Do n	ot enter ti	erry K	oad, C	uch as car	n , ML) 20735 respiratory a	rrest, sh	ock, or hea	rt	Approximate Interval
Physician / / / / / / / / / / / / / / / / / / /	- [failure. List only one cause	on each	n line.												Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		fultiplue to (or as a			5			_					-	
W1		Sequentially list conditions,	b													
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68760, certificate be nding physici se as the buri	Ž,	IF FEMALE:	ho	23c. If yes, o		f pregnancy							23	d. Date of	_	· ·
688 certifi ding	֓֟֟֓֟֟֓֟֟֟֓֟֟֟ <u>֚֟֟</u>	23b. Was decedent pregnant in the past 12 months?	i ic	1 Live bi		-6 -141-	- =	tal death		Ectopic	pregnan	су		Month	D	ay Year
Sox leath e atter for u	Physician/Me	1 Yes 2 No 9 Ur	known	g Unkno			5 Ot	her (Spe	сту)				25			
Division of Vital Records, P.O. Box 68760 La or Attending Physician: The law requires that the death certificate by an abra death. a) Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director.		Part II. Other significant cond	tions o	ontributing to	death bu	t not resultir	ng in the ι	underlying	g cause giv	ven in Parl	t I.					he cause of death?
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tificat		25. Was case referred to medic	al I			-			26.Place	of Death (Check or					2
/ita	ŭ	examiner? 1 ✓ Yes 2 No	_	spital: 1 Ir	npatient	2 Y ER/0	Outpatient	3 🔲 [DOA C	Other4	Nursing	Home 5	Resid	ence 6	Other	
of Physical Reserved	<u>-</u>	27. Manner of Death		28a. Date of	of Injury Day,Year)	28b.	Time of I	njury	28c. Injury	at Work?	- 2	28d. Describe	e how in	jury occurre	ed ff (of 7th floor
tendir eath.	┋│		ding estigation	617	-5-12	fd	1:01	am	1 Y	es 2 🗶 I	No t	nknow	a-of	a hot	tel	7 / CH 1100
ivisior I or Attend after death Director:	<u>≅</u>	3 Suicide 6 Cou	ld not be	28e Place		- At home,			y, office bu	ilding, etc.	. 2					ral Route Number, City
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		30. Name and address of perso Ling Li, MD Assist		mpleted caus dical Exan			Baltimo	re Stre	et, Baltir	more, N	ID 212	223				
Sta	te	-			gistrar's S				, _ 2	1.*						
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Wayne	nemy	Marsh

2	0	Marchita 47 Pa	2	2	3	9	8	2

		Registrar Certificate	of Death	Reg.					
Physician/ Medi Exami		Decedent's Name (First, Middle,Last) WAYNE HENRY MARSH		July 19, 201:					
		4a. Facility Name (if not institution, give street and number) 108 Longfellow Drive	4b. City, Town, or Location of Deat Chestertown	h	4c County of Death Queen Anne's				
Funeral Director			If Under 1 Year If Under 24Hr Months Days Hours Mi		MM/DD/YYYY 9. Birthplace (State or Foreign Country) Maryland				
any	1	Usual Residence of Decedent 10c. City, Town or Loc 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits				
Maryland 28a-f show any dat once.	5	MD Queen Anne's Chesterto	wn		1 Yes 2 X No				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Efficien. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 108 Longfellow Dr.	10f. Zip Code 21 620		Citizen of What Country?				
ith with tems 23	Funeral	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.						
after des ra!", or i	by Fui	or Dates'	Yes 2 X No specify:		specify: White				
2 hours	ed		ent's Usuał Occupation (Give kind of w most of working life. DO NOT use ret		6b, Kind of Business/Industry				
vithin 7	Completed		rical Sales Asso		Electrical Supplies				
e, MD 21215-0036 1 and 2 should be filed within 72 hours after Health and Mental Hygiens. item 27 is marked other than "natural", ir rraumante event, the Medical Examiner.	Be Co	17 Father's Name (First, Middle, Last) Eugene T. Marsh		e (First, Middle, Maid Quasney	len Surname)				
21215 hould be fill nd Mental H is marked tic event, i	10	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Streel and Number or	Rural Route Number	r, City or Town, State, Zip Code)				
nore, MD 21 ages 1 and 2 should nt of Health and Me nt. If item 27 is ma other traumatic ev			S Longfellow Dr. osition (Name of cemetery,		COWN, MD. 21620 Oc. Location - City or Town, State				
		1 Burial 2 Cremation 3 Removal from State crematory or Chester	other place) Cemetery 7/	28/12	Chestertown, MD.				
Balt permit Depart Import injury		21. Signature of Funeral Service Liperisee 22. M00510	Name and Address of Facility Salena Funeral Ho 18 West Cross St	me of Ste	ephen L. Schaech				
Physician /Medical		23a. Bart 1. Exter the disease, or complications that caused the death. Do not enter failure List only one cause on each line.	ne mode of dying, such as cardiac or	r respiratory arrest, s	shock, or heart Approximate Interval Between Onset and				
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tal Reccion The large transfer page 2		25 Was case referred to medical	26.Place of Death (Check	performe 1 Yes 2	No 1 Yes 2 X No				
Vita hysicia this cer	To Be	examiner? 1 X Yes 2 No Hospital 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other Nursi	ng Home 5 Re	sidence 6 X Other Scene				
ion of tending Phyeath. tor: After the funeral	ä	27. Manner of Death 1 Natural 5 Pending Pending Jul 19 2012 28a. Date of Injury FOUND: Day, Year) 1 V Accident Investigation Jul 19 2012 28b. Time of FOUND: Day, Year) FOUND: O911 hrs	Injury 28c. Injury at Work?	28d. Describe how Subject expose temperatures	injury occurred ed to high environmental				
Division of Vital Records, P.O. Box To the Hosp and ratureding Physician: The law requires that the death within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attercompletely filled in by the funeral director, page 2 should be detached for unpletely filled in by the funeral director, page 2 should be detached for uncapted by the funeral director, page 2 should be detached for uncapted by the funeral director, page 2 should be detached for uncapted by the funeral director, page 2 should be detached for uncapted by the funeral director, page 2 should be detached for uncapted by the funeral director, page 2 should be detached for uncapted by the funeral director of the fun	Certificati	3 Suicide 6 Could not be determined (Specific) Single Family Leave	eet, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rural Route Number, City) Chestertown, MD				
To the Hospit within 24 hour To the Funer: completely fill	4 Homicide 108 Longfellow Drive 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the within 7 To the comple	Medical	29c. License number 29d. Date signed (Month,							
		()/ (ulouse)	O.C.M.E.		July 20, 2012				
	ŀ	30 Name and address of person who completed cause of death (Item 23a)	altimore Chart Delliners M	D 04202					
St	ate		altimore Street, Baltimore, M	D 21223					
Regist		31 Date filed (Month Days) 6 2012 37 Registrar's Signalum.	122 C						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15:05pm 201 Medical Facility Name (if not institution, give street and number Examiner 4b. Location of Death 4c. County of Death MMOre pita Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Hours Director 175-30-0876 1 X M 2 🗆 F 74 Yrs. 01/09/1938 PA 10b. County 10a. State 10c. City, Town or Location the Maryland Director 10d. Inside City Limits or 28a-f sh notified a PA 1 Yes 2X No Fulton Warfordsburg 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 17267 USA 266 Church Road items death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Examiner Armed Forces?
1 X Yes 2 □ No
If Yes, Give 106 If Yes, specify Cuban, Mexican, Puerto Rican, etc. , or Black, White, etc. Completed by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Divorced Specify: Year or Dates 1961-63 White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bernard McGuire Helen Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie M.McGuire/Wife 266 Church Road Warfordsburg, PA 17267 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I Important: If ite any injury or otl 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 07/23/2012 Jerusalem Christian Warfordsburg, PA Tune of uneral Service Licensee 22. Name and Address of Facility 141 West Main Street m00528 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca n each line. Interval Between neumonia Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. retai do...
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 Ao 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform After this certificate 1 Yes 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔄 No Other: ည 1 🛂 inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director A 1 Yes 2 No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 Or leans St. Baltimore. MI Kausrus, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Naal 2038pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Nov. 2, 7. Age (In yrs. last birthday)
76 Yrs. **Funeral** 9. Birthplace (State or Foreign Days 1 M 2XXF Hours Director 577-48-3868 Washington, DC Nov. 1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Prince George's Bowie 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 12701 Kernwood Lane 20715 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 XWidowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mildred Schrider Joseph James Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD 20715 12701 Kernwood Lane, Robin A. Putman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place. Department o Important: If any injury or once. 7/11/2012 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 2a. Part 1. Enter the disease, o Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MONI Medical Examiner pulmonary discase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 **Q**lo Other: 1 hpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death. To the Funeral Director: At 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 07-09-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phnapous MD 3140 31 Date filed (Month. State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O. 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #I Per PHY G930 8706/2012 Jn
State of Maryland / Department of Health and Mental Hygiene
1 - State amend item 1 per doc g930 8-14-12 yt
Registrar
Registrar
Reg. No. 2012 1. Decedent's Name (First, Middle, Last)

Isaih Neal, Sr. 2. Date of Death 3. Time of Death 3:30A Physician/ ^{Day}2012^{Year} 7 Isaiah Neal Sr. Medical Facility Name (if not institution, give street and number, Holy Cross Hospital 4b. City. Town, or Location of Death Silver Spring **Examiner** 4c, County of Death
Montgomery If Under 1 Year If Under 24 Hrs. 579-56-4536 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 9/20/1943 Hours 69 North Carolina **Director** 1**X** M 2 □ F Usual Residence of Decede 28a-f show 10c. City, Town or Location be notified at 10d. Inside City Limits Director DC Washington 1 X Yes 2 □ No 10e. Street and Number 2904 26th St. NE 10g. Citizen of What Country? 10f. Zip Code ö 20018 23a Funeral injury or other traumatic event, the Medical Examiner must or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No δ 1 Never Married 2 Married Specify Black Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) DC Housing Auth. Mechanic Be Father's Name (First, Middle, Last, Shelton Neal 18. Mother's Name (First, Middle, Maiden Surname Betty Irene Dunston permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2904\ 26$ th St. NE Washington, DC 20018 19a. Informant's Name/Relationship (Type, Print) Alfreda Neal/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Riverdale, MD 7/13712 cemetery, crematory or other place Riverdale Park 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility
Murray Funeral Home-Washington, DC 20019 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physicians disease or condition Decu Medical resulting in death) Du to (r as a conseq nce of) **Examiner** Securitiesly lift renefficies if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of that the death certificate be executed Cause (Disease or injury that initiated events lumonia attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown g Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed? Yes 2 director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 27. Mann Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only on 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) D32332 07 - 09 - 12U Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta-9801 Georgia Asso Gupta-9801 Georgia Ave. Silver Spring, MD

State Registrar strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month JOHN ANTHONY OTTAVIANO 2012 4:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAGERSTOWN MERITUS MEDICAL CENTER WASHINGTON Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** . Age (In vrs. last birthday 1 X M 2 🗆 F Months Days 199-28-4173 72 **Director** 12/18/1939 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director WV BERKELEY MARTINSBURG 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 1024 WINCHESTER AVENUE 25401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. "natural", 3 Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SALES AUTOMOBILE 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
AMELIA UNKNOWN မ NICHOLAS OTTAVIANO should and Me 19a. Informant's Name/Relationship (Type, Print)
MARIE OTTAVIANO/ FORMER DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, and 2 s Health : 215 GRENADINE COURT, MARTINSBURG, WV 25404 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY SMITHSBURG, MD any injury . Signature of Funeral Service Licens 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 41814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** EVMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last MYERO DYSPLASTIL Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) signed by the atte in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of death? Yes 2 V No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💆 No Other: ပ္ 1 DInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death. 2 Accident injury work?
1 Yes 2 No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADIR 20311 (LOM) 1500N8850RD AMPANS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

				or		State	of Mar	yland	/ Depa	rtment of F	lealth a	ınd M			49-18	
		7	_ R	tate egistrar	e (First, Middle	(ast)			Cer	tificate of L	Jean	T	2. Date of Deat		Voor	3. Time of Death
	Physician	/	. Dec		KLIN	DELAN	0 F	ETRU	CCI				JULY 1		O12 Year	7:00 A M
men.	Medica Examine		a. Fa	cility Name (if	not institution, HOSPIC	give street and E HOUSE					T. A1	RY			CARRO	pplace (State or Foreign
_	Funeral Director	5		ial Security N		6. Sex 1 M 2 D		In yrs. last 30	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day 5/14/1	932	WES	ntry) VIRGINIA
7	show			Residence of	10b. County			10c. City,	Town or Lo	cation RTINSBUR	G					10d. Inside City Limits X1X□ Yes 2 □ No
A CANADA	or 28a-f		W 10e. 8	Street and Nu	mber	RKELEY				10f. Zip Code	25401			10g. Citiz	zen of What Co	
36	permit. Page 1 and 2 should be flied within 72 hours after death with the Marylau or Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	P. P.	11. M	arital Status	BURKE	ried Arme	Decedent Ev d Forces? Yes 2 \(\sum \) s, Give or Dates.			Was Decedent of High Yes, specify Cub	an, Mexicar	i, Pueno i	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:	
21215-0036	thin /z houls ene. than "natural he Medical Ex	Completed		-	15. Decede ecify only high	nt's Education est grade compl)	(Give life. E	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES					nd of Business	BAKING CO.
nd 2	e filed wit tal Hygie ed other event, tt		17. F	ather's Name	(First, Middle,	Last) RUCCI					18. Moth	ner's Name MAR	e (First, Middle, LY SALAD	Maiden S INI	Surname)	
Maryland	2 should b th and Mer 77 is mark traumatic		19a			ship (Type, Print) N/DAUGH	TER		19b. Mail 97	ing Address (Stree 43 REDAM	t and Numb AR DR	er or Rura [VE,	HAGERS			
nore, l	nt of Heali nt of Heali t: If item 2		20a.	Method of Di	sposition Cremation	n 3 □ Remova (Specify) ENTO	from State	20b. Pla	EDALE (osition (Name of matory or other pl EMETERY	ace)	JULY	2012		ocation - City of	JRG, WV
Baltimore,	Departme Importan any injun				uneral Service		ids		2	22. Name and Add	ress of Facil	BRO	OWN FUNER RTINSBURG	AL HO , WV	ME, PO BO 25402	OX 821,
	be executed sician and sician and burial-transit	Examiner	Se if a car	a. Part 1. Ente shock, or he mediate Causease or condi- ulting in death quentially list my leading to use. Enter Un- use (Disease at initiated eve- sulting in death	eart failure. List e (Final tition tit) conditions, immediate derlying or iinjury nts	a. D	that caused on each line A ue to (or as	a consequ	uence of):	eter the mode of dy				rrest,		Approximate Interval Between Onset and Death IE MIATE
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF F	EMALE: b. Was deceded in the past 1 Yes g Unkno	I2 months? 2 □ No wn	1 L 4 E 9 E	Pregnant a	2 ∐ Feta at time of a	al death 3 death 5	☐ Ectopic pregn)				23d. Date of c	lelivery Day Year to the cause of death?
rds, P.0	equires that the equires that the signed by hould be detail	eted by Pl	Pa	rt II. Other sig	nificant cond	itions contributi	ng to death	out not res	sulting in th	e underlying cause	given in Pa	irt 1.	1 [24a. Wa	Yes 2	No 3 🗆	Probably 4 Unknown autopsy findings available o completion of cause of
Reco	ician: The law I certificate has k rector, page 2 s	Completed								0.6	Diago of D	eath (Che	pe	formed?	death	? /es 2 \(\sum \text{No} \)
Division of Vital Records,	hysician: this certific al director,	To Be	25	examiner? 1 Yes Manner of D Natural	5 Per	Hospita 28	il: 1 Inpa a. Date of in (Month, D		ER/Outpa 28b. Time injur	tient 3 DOA		Nursing I	Home 5 Re 28d. Describ	e how inju		170000
ivisior	or Attendate death	Certificate:		2 Accide 3 Suicide 4 Homici	e 6 □ Co de det	uld not be ermined 28	building, e	tc. (Specii	Ty)	street, factory, off			City or 1	own, Sta	te)	Rural Route Number,
۵	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical		9a. Certifier (Check only one)	1 Certify 2 Medic	ying Physician: al Examiner: Or ying Nurse Prac	To the best of the basis of the trioner: To the	of my knov examination e best of r	wledge, dea on and/or in ny knowled	ath occured at the vestigation, in my oge, death occurred	time, date a opinion, deat at the time, o	nd place, h occurred date and p	and due to the d at the time, dat blace, and due to	the caus	e(s) and manner	as stated.
	To the within To the comple	2	25		and title of cer		ulo	w1	MO	29c. Lic	cense numb	er		29d. [Jate signed (IVIC	onth, Day, Year)
	59		3	0. Name and a	address of pers	son who comple	ted cause of		em 23a) (Tyr	pe, Print)	Ladice	j d	(Emplo)	He	seration	in MP.
1	S Regi:	tate trar		1. Date filed (Month, Day, Ye. 2 7 2	012 Ser	32. Regis	trar's Sign	park	led .						

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Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Powell Elsie Ann 18:25 July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10429 Brighton Road Ocean City Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Hours Min (Month, Day, Year) Director 215-38-3596 1 M 2 X F 70 Nov. 14, 1941 Hyattsville, MD filed within 72 hours after death with the Maryland al Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10429 Brighton Road 21842 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 12 Management Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Jacob Bryan Huffer Elsie Lee Boteler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene K. Walton / Daughter 3424 Matagorda Springs Drive, Plana, Texas 75025 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Important: It any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 7/11/12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory anest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical (or as a consulate Examiner Sequentially list conditions, Examine fary, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation s after deat Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2012 on who comple d cause of death (Item 23a) (Type, Print) 30. Name and address of per 100 MD Ε. Carroll Street, Jimmy Taylor, Salisbury, MD 21801

State Registrar 31. Date filed (Month, Day, Year)
JUL 1 3 2012

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PHILLIPS MELISSA 1:05 Medical Y.IIIT. 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST GLEN NURSING STLVER SPRING
If Under 1 Year I If Under 24 Hrs MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director 100 579-56-9945 1 □ M 2 🗓 F SC Yrs MAY 22, 1912 Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No SILVER SPRING MONTGOMERY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 2700 BARKER STREET 20712 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other then " Elementary/Secondary (0-12) College (1-4 or 5+) .mor.,
.nit. Page 1 and 2 sho..
.ment of Health and Men..
.tit lem 27 is marked oth..
.ar traumatic event, the PRIVATE HOUSEWIFE 11TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ESSIE SHULER RUFUS JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EASTERN AVE, MOUNT RAINIER, MD 20712 IEAN BROWN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. LANDOVER, MD 7-13-12 HARMONY MEMORIAL 21. Signature of Funeral Service Lice 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. MO1085 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. 23a, Part 1. Enter the disease Immediate Cause (Final Atherosclerotic Onset and Death Physician/ Cardiovascular disease disease or condition resulting in death) INKHOWN Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physiclan/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by dementia, Senility, Records, 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinating and/or investigation is an examinating and/or investigation. Medical 29a. Certifier To the Funel completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis or examination and/or investigation, in till opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

DA

howde

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHOWDAURY, MD; 605 Main St., Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and N ertificate of Death		2012	23990
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. 2. Date of Death	No. 2012	
п	Physicia Medic		Barbara Ellen Donchey Pattin		Month July 11	Day 2012 Year	3. Time of Death 12:10 PM
proces.	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
المعاصات			6907 Lyle Street	Lanham		Prince G	le orges
	Funeral	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birtho	lace (State or Foreign
	Director		120-26-2356		(Month, Day, Yea May 13 1	936 New	York
	nd how at	=	10a. State 10b. County 10c. City, Town or	Location		10	0d. Inside City Limits
	aryla sa-f s ified	Director	Maryland Prince Georges Lanham				1 X Yes 2 □ No
	or 28	ᄚ	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Coun	try?
	with 23a ust b	Funeral	6907 Lyle St	20706		USA	
	tems er m	뜶	11, Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - America	an Indian,
9	fter d , or i	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.
8	urs a tural	ted	3 ★ Widowed 4 □ Divorced Year or Dates.	1 Yes 2 No Specify:		Specify: Whi	te
7	72 ho	Completed	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work	ing 16t	o. Kind of Business Ind	lustry
12	ithin ene. r thar	ő	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	S	elf Employe	ed
p	Hyg othe	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	은	Solomon Donchey	Sophie	Friedman	,	
lan	shoul and I is ma	.5		ailing Address (Street and Number or Rura	al Route Number, City	y or Town, State, Zip C	ode)
€,	and 2 Health		112011 20100217 (2011)	Via Mimosa San Cle			
lore	ge 1 ant of h		1 Purial 2 Transition 2 Pamoual from State Cemetery C	rematory or other place)	I	c. Location - City or To	· ·
Ħ	it. Pagintmer interioritant injury			ake Crematory 07/1. 22. Name and Address of Facility Ren	6/2012 Be	Itsville, i	Maryland
Ba	permi Depar Impol any ir	V.	21. Signature of Juneal Service Licensee	9013 Annapolis Rd.	Lanham,	Maryland 2	0706
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition a. Acute Leukemia			2	Onset and Death Months
	Medical Examiner		resulting in death) Due to (or as a consequence of):				
		er	Sequentially list conditions, from leading as immediate by Due to lor as a consequence of	ocytic Leukemia		1	year
	ed nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury				
	xecut n and al-tra	Еха	that initiated events c. Due to (or as a consequence of):				
09	ate be executed ohysician and the burial-transit	dical	d				
876	ificate ng phy as th	Med	IF FEMALE:				
ŏ ×	attending p	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delive	ry
Box 687	death he ath	Physician/Me		Other (specify)		Month	Day Year
P.O.	at the d by 1 letach		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e Did tobacc	co use contribute to the	a cause of death?
S,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	d by		, ,	1	2X No 3 ☐ Prob	
ord	requ been shoul	lete			24a. Was an		sy findings available
ec	The law cate has page 2 s	Completed			autopsy performed	prior to con death?	npletion of cause of
<u>=</u>	sician: The certificate rector, pag	o l	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 X	No 1 ☐ Yes	2 ⊔ No
Ę.	Physician: r this certificantal director, i	To B	examiner? 1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other:		6 Other (Specify)	
of	ding Ph th. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at	28d. Describe how in		
o o	tendii eath. or: Ai the fu	ifice	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Att	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural I ate)	Route Number,
۵	pital ours a eral [29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occured at the time, data and place on	d due to the server(e)) and manner as states	
	e Hos 1 24 h e Fur ileted	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the caus	se(s) and manner stated
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	2	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	
	n		6 Cymul mg	MD7655	07/	12/2012	
	th		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Bruce Kressel 2141 K Street N	W Washington, DC 20	0037		
	Stat	e	31. Date filed (Month, Day, Year)				
	Registra		JUL 1 3 2012 Januar Jd. Jake				:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Valaida Lee Parker 6, 2012 0003 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Health Center Harford Bel Air If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, May 6, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 218-40-9669 1 ☐ M 2 😾 F Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ural", or items 23a or 28a-f shov I Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 79 Clark Lane U.S.A. should be filed within 72 hours after death vand Mental Hygiene. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 🏋 No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" Completed nit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natuu injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground College (1-4or 5+) Elementary/Secondary (0-12) Aberdeen, Maryland Two Years Logistical Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie Hobbs Ella E. Clark ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carnell Parker (Husband) 79 Clark Lane, P.O.Box 81, Port Deposit, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If 4 □ Donation 5 □ Other (Specify) Cokesbury Cemetery 07/16/12 Port Deposit, Maryland 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perrvville. Maryland 21903-0766 21. Signature of Funeral Service Licenses Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician h micro /Medical ue to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar ue to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available certificate has autopsy performed 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 Tes 2 40 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending | Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d_Date signed (Month, Day, Year)

within 24 hours a To the Funeral L

PARKER

State

30. Name and address of person who completed caus

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31. Date filed (Month, Day, Year)

Registrar

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of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Lawrence Proctor July 9, 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3015 Laurel Avenue Cheverly Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 577=88-7359 **Director** 1 X M 2 A F 53 June 28, 1959 Usual Residence of Decedent or 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director Prince George's Maryland Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3015 Laurel Avenue 20785 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) d Mental Hygiene. marked other tha Computer IT Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ! 2 James Alfred Proctor Velma Joan Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 3015 Laurel Avenue, Cheverly, MD 20785 Ethel M. Dancy / Spouse injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State 7/10/2012 4 Donation 5 Other (Specify) Alexandria, Virginia Metropolitan Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Lou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of): **Examiner** Adenocarcinoma of the Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pancreatic Cancer Records, 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🛚 Residence 6 🗆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe h eral Director: After filled in by the funer X Natural 5 Pending

ath 5 ☐ Pending Investigation 6 ☐ Could not be	injury 28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred							
determined 28e. Place of	Injury - At home, farm, street, fa, etc. (Specify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
title of certific		29c. License number Wb31152		29d. Date signed (Month, Day, Year) July 10, 2012						

24b. Were autopsy findings available prior to completion of cause of death?

Month

1 Yes

3. Time of Death

Ам

2:35

9. Birthplace (State or Foreign

Washington, DC

Approximate Interval Between

Onset and Death

USA

Black, White, etc.

10d. Inside City Limits

1 X Yes 2 No

31. Date filed (Month, Day, Year) 2012 Registrar

Accident

29a. Certifier only one)

Suicide

BROWN 43-92 4302 St. Barmabas Rd. 5-B, Temple Hills, MD

the Funeral

within 7 0

Medical

PCP Williams Kinghet State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 3 м nn 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) South Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year **Funeral** Days 1 ▼ M 2 □ F 248-02-4650 Director Yrs 58 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 X Yes 2 ☐ No Maryland Ceci1 Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 917 Frenchtown Road 21903 U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces's Black, White, etc. 1 Never Married 2 M Married ò þ 1 X Yes hours after 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural", res, Give Year or Dates 1971 – 2000 Specify: 3 Widowed 4 Divorced Completed White other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business Industry Aberdeen Proving Ground 2 should be filed within 72 th and Mental Hygiene.

27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Inspector Aberdeen, Maryland <u>Twelve Years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ō James O. Rauton Margaret P. Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is. J. Tipton O'Bannon (wife) 917 Frenchtown Road, Perryville, Maryland 21903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) R.A.Ferris & Co., Inc. 07/09/12 Pennsvlvania 21, Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Orona Medical Due to (or as a conseque Examiner Sequentially list conditions, rany, leading to influedate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 signed by the attending part be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death Year 9 Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe Yes 2 X No certificate 2 DV6 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 ည 1 Inpatient 2 €R/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 1 Natural 5 Pending 2 🗆 No Accident Investigation Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatuye 29d. Date signed (Month, Day, Year) d address of pe of death (Item 23a) (Type, Print) ho completed 7+1 VA 31. Daye filed (Month, Day, Year) 32. Registrar's Signature State Man Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month July 2012 Year 10:20 A M Doris M. Reynolds Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Union Hospital Elkton Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Months Hours Min. 8/4/1921 Director Yrs. 90 214-16-4644 MD Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rising Sun MDCeci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 N. Walnut Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Teacher Public Schools permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked othe any injury or other traumariconce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Reynolds Taylor B. McVey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Earle Branch Road, Centreville, MD 21617 Robbin C. Twilley - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cem. 7/12/12 Rising Sun, MD Signature of Funeral Service 22. Name and Address of Facility R.T. Foard Funeral Home, PA 111 S. Queen Street, Rising Sun, MD 21911 23a Part 1. Enter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ e Medical Examiner Difficile C. D. +M lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause iDispersion Examiner Due to (or as a consequence of physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or it that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 4 ☐ Pregnam 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 8hoe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has k autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pendina 1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title di

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STLAIL

C10005113 DE

12-04986

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stella Jean Reeve	1 F	l- For State Registrar		ite of Maryla		artment of <i>rtificate of</i>		and Mental		Reg. No.	201	2 2399
Physician	1	1. Decedent's Name	e (First, Middle,	Last)					2. Date of De Month	Day Ye	ar	3. Time of Death 1221 hrs
Medical Examine		St.	ella Je	ean Reeve	S	1	In City Tours	or Location of De	July 3, 20	14c. County	of Death	12211118
		160 Ebenez		= -	niber)		Rising St		odu i	Cecil		
Funeral	7	5. Social Security N	lumber 6	S. Sex	7. Age (In yrs. I	last birthday)	If Under 1		Hrs. 8. Date of B	irth(MM/DD/YYY	Y) 9. Birth Foreign	hplace (State or
Director		215-44-12	214	1 M 2 X F	63	Yrs.		Days Hours I	05/1	8/1949		eWnsylvania
,	-	Usual Residence of 10a. State	Decedent 10b, County		10c. City	, Town or Locati	on					10d. Inside City Limits
T 00 51		Maryland	Ceci	1	1	Rising						1 Yes 2 No
uylanı Sa-f sk	<u>5</u> -	10e. Street and Nur		L		KISING	10f. Zip Cod	e		10g. Citizen of W	hat Coun	try?
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er death with the Maryland or items 23a or 28a-f show any Craust be notified at once	<u></u>	11. Marital Status		12. Was Dece	edent Ever in U		s Decedent of		(Specify Yes or N	o- 14. Rac		can Indian, Black,
death or ite		1 Never Marrie		1 Yes	2 X No				ento reican, etc.)		•	
ral",		3 Widowed		rced If Yes, Give Year or Dates: fy only highest grad			Yes 2 X	No specify: pation (Give kind	of work done	Specify: 16b. Kind of B	Whit	
5-0036 ed within 72 hours aft tygene. other than "natural" the Medical Examine	<u> </u>	Elementary/Seco		College (1-				life, DO NOT use		TOD. KING OF B	23111033711	idusti y
036 thin 7 ne. rethan		9				Secr	etary			Home	Buil	der
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name	(First, Middle, L	.ast)		•	1	18.Mother's Na	ame (First, Middle,	Maiden Surname))	
d be file fental larked event,		Rufus F	liram R	ay		10h Mailine	Addross (St	Lucy	Blanche	Elliott	. State	Zip Code 21911
MD 21 nd 2 should alth and Me alth and Me m 27 is maranaric cv	-				C							
9, M and 2 fealth item 2		James A. 20a. Method of Dis	position	s, Sr. /		Place of Disposi	tion (Name of	cemetery,	Road,Ri Date	20c. Location	- City or T	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Eumaral Director		1 X Burial 2		3 Removal fro		crematory or oth on Chur		etery J	uly 9, 2012	Elkton,	. Mar	yland
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Physician /Medical	1		e disease, or co ly one cause o	omplications that ca n each line.	used the death	. Do not enter th	e mode of dyi	ng, such as cardia	ac or respiratory ar	rest, shock, or he	art	Approximate Interval Between Onset and
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376(ificate g physis the b		IF FEMALE: 3b. Was decedent		23c. If yes, o	utcome of preg		al death	3 Ectopic pre	gnancy	23d. Date o Month		ay Year
x 68 h certi	2	past 12 months		4 Pregna	ant at time of de	— I	ner (Specify)					
). Box 6876 the death certificate by the attending phyched for use as the Dhycician/W	2	1 Yes 2 🗸 1		a OUKUO					100- B:4		75 - 4 - 1 - 1	4 1-11-0
Division of Vital Records, P.O. Box 6876 tal or attending Physician: The law requires that the death certificat is after death. **I Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the partification: To Re Completed by Diversional Management		Part II. Other signr	ficant conditio	ns contributing to	death but not r	esulting in the u	nderlying caus	se given in Part I.	_ I	_		he cause of death?
n of Vital Records, P.C. sing Physician: The law requires that After this certificate has been signed funeral director, page 2 should be deter												opsy findings available
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/ital	ן בֿ	examiner?	2 No	Hospital: 1 Ir	npatient 2	ER/Outpatient		Othor	rsing Home 5	Residence 6	✓ Other:	Scene
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Division or Hospital or Attending Hoppital or Attending Funeral Director: After telly filled in by the funeral Director.		3 Suicide	6 Could determ	not be 28e. Place		ome, farm, stree	t, factory, offic	e building, etc.	or Town,	State)		al Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transluding Certification: To Re Completed by Diversion Modical Examples of the contribution of the complete of the contribution of the contribution of the complete of the contribution	3	(Check only ' -		iner:On the basis o	f examination a	-						
T K I I		29b. Signature and	title of certifier	and manner st	arou.		29c. Lice	ense number		29d. Date sign	ed (Mon	th, Day, Year)
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Stat		Jack Titus N 31. Date filed (Mont		ty Chief Medic	ai Examine gistrar's Signati			ueer, Dailimo				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ L. Roberts July 6 2012 Medical 6:14 a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2901 Pine Bluff Circle Temple Hills Prince Georges **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Days (Month, Day, Year) Hours 247-94-619 Director 1 **X**M 2 □ F 59 12-24-1952 South Carolina sa or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. Temple Hills 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2901 Pine Bluff Circle 20748 U.S.A. or other traumatic event, the Medical Examiner must items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Black Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Secondary (0-12) Computer Technician Private should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mason Roberts Annie L. Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **2901 Pine Bluff Circle, Temple Hills, Md. 20748** Health a Edna Ford-Roberts - Wife Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If its any injury or ot 4 Donation 5 Other (Specify) Riverdale Pk Crematory 7-17-12 Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRonald Taylor, II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause deach line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be as IE EEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 Yes 2X No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DCA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and 🖠 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) D.O. Cheathan 5100 (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $^{\text{D}}\!\hat{2}^{\text{Y}}\!012$ Physician/ July 5, 3:45 A M Claire Rice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Capitol Heights 852 Brooke Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Social Security Number Min (Month, Day, Year) Director 578-22-<u>5338</u> 1 🗆 M 2 🖾 F 92 1919 South Carolina 3. 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Capitol Heights <u>Maryland</u> Prince George's 10 10f. Zip Code 10g, Citizen of What Country? 23a Funeral United States 20743 852 Brooke Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give or þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Licensed Practical Nurse Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jordan Higgins Nancy Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 i 20743 Cynthia Higgins - Granddaughter 852 Brooke Road Capitol Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important; If ite any injury or ot $\mathtt{July}^{\mathtt{Dat}} \hat{\mathtt{I}} \mathtt{1}$. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 2012 Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Som Store 1-20019 4001 Benning Road NE Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 2 **years** Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cerebro Vascular Accident l year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has to page 2 s autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director. After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 $\stackrel{igstyle igotimes}{igotimes}$ Residence 6 \square Other (Specify) 1 🗌 Yes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 \square Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

4 Homicide

only one) 29b. Signature and title of certifier

Kevin G. Nealon

29a. Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

5215 Loughboro Rd. NW

32. Registrar's Signature

Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0023127

Suite 440 Washington, DC

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

July 10, 2012

	7	For State Mengrar#201	nor a						lealth and N	Mental Hy	giene Reg. No	6016	23998	100
	F	1. Decedent's Name (F			/10/	12 FC	צנטו יעצנ	2010 07 1		2. Date of De	eath		3. Time of Death	-
Physicia		PRISCILLA '	VICTORIA	ROACH						JULY	8 Da	2012	5:25 A M	
/Medica Examine		4a. Facility Name (If no.					4b.	City, Town, or	r Location of Death		40	c. County of Deat	th	
		LARKIN CHA						WIE				?G		_
Funeral		5. Social Security Numb	1	м 210 г	7. Age (In)			nder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di MARCH	ay, Year) Co	thplace (State or Foreign ountry)	
Director	-	580-08-9012 Usual Residence of De			96					MAKCH	1 e 1	1916 WEST	L INDIES	-
yland			b. County			•	or Location	1					10d. Inside City Limits	
e Mar	ctor	MD	PG		BO	WIE							1 Yes 2 No	
or 28	Director	10e. Street and Numbe						f. Zip Code				itizen of What Co	ountry?	
s 23e		13304 KATR		12. Was Dece	dont Ever i	0118		20720	lispanic Origin? (Sp	acifu Vas or N	US	14. Race - Ame	ancan Indian	_
Item de	Funeral	11. Marital Status 1 ☐ Never Married		Armed Fo 1 ☐ Yes	rces? 2 🕅 No	11 0.3.	If Yes,	specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, Whit		
sl', or	Ď	3 ☐ Widowed 4 🗶		If Yes, Giv Year or Da	e		1 🗆 Y	es 2∭ No	Specify:			Specify: BLA	ACK	
72 ho	Completed		. Decedent's Edu			16a.	(Give kind o	Usual Occup	during most of worl	king	16b. l	Kind of Business	/Industry	
hen.	mple	Elementary/Seconda		College (1	-4or 5+)			OT use retired	d)					
Hygie thert int.		8TH 17. Father's Name (Firs	st. Middle. Last)			CA	RETAK	ER	18. Mother's Nam	ie (First, Middle	-	IVATE n Sumame)		-
d be tended of ceve	o Be	·	o,o.,,						ROSEANNA	•			,	
shoul nd Me mark	ို	UNKNOWN 19a. Informant's Name	A/Relationship (Ty	pe, Print)		19b.	Mailing Add	dress (Street	and Number or Ru					
elth a		JANET JACK	SON/NIEC	E		13	304 K	ATRINK	A DR. BOW	TE. MD.	207	20		
of He of Herr	T Î	20a. Method of Disposi		lamoval from		b. Place of	Disposition	(Name of	metery	Date	20c. l S1	Location - City or uitland	Town, State	
Pagement ment and: Manual ury o		4 Donation 5		iemovai irom	F	T. LI	NCOLN	CEMET	ERY 7-14		BR	ENTWOOD,	- MD	
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show eny Injury or other traumatic event, Ite Modical Examinar mast to notified at once.		21. Signature of Congr							ss of Facility PO					
Ø0 = € Ø		7 7	1	1423		145 D			ORO PIKE,			LE, MD 2	.0747 Approximate	
			flure. List only or	ne cause on e	ach line.				ig, such as cardiac	or respiratory	arrest,		Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Fin disease or condition resulting in death)	ai 💮	1				SEASE		·			YEARS	_
Examiner			- 1	Due to	(or as a con	sequence	of):							
	Jer	Sequentially list condit if any, leading to imme cause. Enter Underlying		Due to (or as a con	sequence	of):							-
be executed sicien and burial-transit	Examin	that initiated events	ity	c										
e exe ien ar urial-t	EX	resulting in death) Last	'	Due to	(or as a con	sequence	ol):							
ate	edical			d										-
eath certific attending p	/Me	IF FEMALE:	2	3c If yes, out	come of pre	agnancy						22d Date of de	liven.	
atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months? in the past 12 months? in the past 12 months? in the past 12 months? in the past 12 months? in the past 12 months?								23d. Date of delivery Month Day Year				
the d sy the eched	hysi	1 ∐ Yes 2 🔼 N 9 ☐ Unknown	0	9□ Unkn	own									
ires that the de signed by the d be deteched i	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								use contribute to	use contribute to the cause of death?			
w require been sig should b		ELECTROLY	TES LIME	ALANIA	, SEP	SIS	-			1 🗆	Yes :	2 X No 3 □ P	robably 4 Unknown	_
hes be	plet									24a. Wa auto	opsy	prior to	utopsy findings available completion of cause of	
The page	Completed									per 1 ☐ Yes	formed? 2√∑N	death?	s 2□ No	
yeiclan: The is certificate hidrector, page	Be	25. Was case referred examiner?		lospital:				J. Ott	26. Place of Dea					_
Physical dir	^L	1 ☐ Yes 2 No 27. Manner of Death		28a. Date		2 ER/Ou	tpatient 3[_ DOA _	4 ty Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Spe	ecify)	
or Attending I after death. Director: After in by the funer	tion	*7	5 Pending investigation	(Mon	th, Day Yea		njury N	28c. Injui Wor 1 □	rk? Yes 2 □ No			,		
after death. Director: A	fica	3 Suicide	6 Could not be determined				rm, street, fa	actory, office		281. Location City or To	(Street a	and Number or R	Bural Route Number,	_
s afte	Certification:	4 Homicide		Buildi	ing, etc. (Sp	<i>Эөспу)</i>				City of 1	own, sta	110)		
hour hour uners	edical (me, date and place					_
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	Medi	one)			ner stated.			29c. Licens						_
T Wilt	~	29b. Signature and title	e of certifier				`	D005				Date signed (Mon		
5		- Ha	~~~ -	DF. TV	1	(thom com	(Type Peter)		- 107			-10-12	>	_
4		30. Name and address DARCY IBIT							GI.ENDALI	E. MD 20	0769			
Sta	te	31. Date liled (Month,	Day, Year)	32. F	Registrar's S	iggature		112729	CLLINITI	-, 2				-
Registr	ar	JUL 1 1	ANTZ PL	nous 1	A. 1	park								_
	_					_								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13, Day Ju^{Month} 201^Y2^{a1} Elizabeth 7:10A. Rice Mary Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Silver Spring **Examiner** 4c. County of Death Prince George's Renaissance Gardens at Riderwood Village Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 225-46-6207 Aug. 10, 1914 1 🗆 M 2 🔀 F **Director** 97 West Virginia 28a-f show 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland Prince George's Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? 23a 3160 Gracefield Road, #EG2201 20904 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, 9 þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: White "natural" Completed 3X Widowed 4 □ Divorced Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.
7 is marked other than 'traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ల Ballard P. Shumate Meador Lizzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 Wanderring Fox Trail, #207 Odenton, Maryland 21111.3 ge 1 and 2 sl it of Health a : If item 27 i Robert J. Rice, Jr. -son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State injury or Fort Lincoln Cemetery 7/18/2012 Department of Important: If any injury or Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Donald doctor Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ 15years disease or condition resulting in death) Arteriosclerotic Cerebral Vascular Disease Medical Due to (or as a consequence of Examiner Hypertension 25 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE nse 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) jo in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform performed?

1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ျာ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending ☐ Accident Investigation 1 Tes 2 No the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 1586067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

2 6 2012

			For State Registrar	Glate of Warylar		rtificate of			g. No. 2	12	24000		
ď	Physici	an	1. Decedent's Name (First, Middle, L.	ast)				Date of Death Month	Day	rear .	3. Time of Death		
	/Medic	al	Mae Celia Rober					July 1			6:00 a. M		
	Examin	er	4a. Facility Name (If not institution, gi				r Location of Death		4c. County of Death Allegany				
1 5			Moran Manor Nu 5. Social Security Number 6.	Sex 7. Age (In yrs.	last hirthday)	If Under 1 Year	ternport	8. Date of Birth	1	_			
	Funeral Director			1□M 2\\ F 99		Months Days	Hours Min.	(Month, Day, Nov. 9,1	912	Coun:	ace (State or Foreign try) Sville, WV		
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	ncation			-	10	Od. Inside City Limits		
	aryla shov ed at	'n								.	1 □Yes 2 No		
	the M 28a-f otifie	ecto	WV Miner 10e. Street and Number	aı	Dul	rlington		10	ng. Citizen of Wi	nat Coun	trv?		
	with with the r	Funeral Director	Rt. 1, Box 179				6710		US		,		
	ns 23 mus	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. 1			ecify Yes or No-	14. Race	- America			
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a be notified at matic event, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:]Yes 2.1⊠No es, Give 1 □ Yes 2.1ℤN <i>o Specify:</i>					Rican, etc.) Black, White, etc. Specify: White			
5-0036	2 hou	ed	15. Decedent's I	Education	16a. Dece	dent's Usual Occup	pation	1	l6b. Kind of Bus	iness/Inc	lustry		
212	hin 7%	plet	(Specify only highest g	College (1-4or 5+)	(Give life. i	DO NOT use retire	during most of work d)	ing					
2121	d with	Completed	8		Нс	omemaker				Hom	e		
g	al Hygi al Other vent, t	Be (17. Father's Name (First, Middle, Las				18. Mother's Name	•)			
<u>ya</u>	should be nd Mental marked o	ျှ	George Rohrbau				1	rude Kep					
ā	2 sho		19a. Informant's Name/Relationship			•	and Number or Rur		-		Code)		
ď	l and lealth		Galen R. Robert 20a. Method of Disposition				81-A Bur		WV ZO 20c. Location - C	710	wn State		
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemovai from State		osition (Name of matory or other pla emetery		15,2012	Antic				
Balt	permit. Pag Department Important: any injury conce.		21. Signatur Service Liv	Sull		2. Name and Addre	ess of Facility Sm .n Street	ith Fune Keyser,		e 726			
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	an Due to (1) as a consect		_	_			to	Approximate Interval Between Onset and Death		
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Se ventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):										
Vital Records, P.O. Box 68	The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	Physician/Med								23d. Date of delivery Month Day Year			
D	that ned by deta		Part II. Other significant conditions	s contributing to death but not re	sulting in the u	ınderlying cause gi	ven in Part I.	23e. Did tob	acco use contri	bute to the	ne cause of death?		
g	quires n sign ald be	d by	Hypertens	ion 1 Hy	perlip	edenis	<u> </u>	1 □ Ye	s 2 No	3 ☐ Prob	ably 4 Anknown		
Reco	ne law rec has beer ge 2 shou	Completed	- / /					24a. Was ar autops perforn	ned? p	rior to co eath?	psy findings available mpletion of cause of		
g	n: Th		25. Was case referred to medical				OS Place of Door			□Yes	2 No		
5	sicia certi irecto	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	□ FR/Outpatie	nt 3□ DOA Ot	har:	th <i>(Check only one</i> ome 5 ☐ Reside		r (Specif			
on or	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1 ☑ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	ury at ork?	28d. Describe ho			<i>y)</i>		
Division or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined elemented building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nur City or Town, State)							er or Rura	al Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical C		Physician: To the best of my kr caminer: On the basis of examinand manner stated.									
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed	(Month,	Day, Year)		
			1 cm	//-		D	21244		7/111	120	12_		
(30. Name and address of person wh	no completed cause of death (Ite	em 23a) (Type,				1101				

State Registrar 31. Date filed (Month, Day, Year)

4 Broadway

Jesus Tan, M.D.

Frostburg, MD

21532